PRICEWATERHOUSECOOPERS

Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross for the State of Washington

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October 27, 2003

Prepared for the Washington Office of the Insurance Commissioner

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EXECUTIVE SUMMARY

On September 17, 2002, Premera Blue Cross filed a Form A application to the Washington Office of the Insurance Commissioner to convert from a non-profit health services contractor to a for profit publicly traded health insurer.[1] The company filing states that the full value of the proceeds of the conversion would be transferred to a foundation with the assets used to serve the health care needs of the populations of Alaska and Washington, the two states in which Premera operates as a non-profit.

PricewaterhouseCoopers LLP (PwC) was retained by the Washington Office of the Insurance Commissioner to assess the potential market impact of the proposed conversion of Premera Blue Cross on the Washington health care market. A separate report is being prepared by another firm that considers the effect of the proposed conversion on the Alaska health care market.[2] The market impact analysis was structured to address questions related to potential changes in the health care market and insurance coverage in Washington resulting from the transaction. As such, we examined the following issues and assessed their likely impact as a result of the proposed transaction:

- The impact on policyholders' coverage if this transaction is completed;
- The impact on health care providers; and
- The impact of this transaction on the insurance marketplace.

The OIC created a set of instructions to consultants that guided our analysis. Among the instructions pertinent to this report are the following:

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[1] Form A: Statement Regarding the Acquisition of Control of a Domestic Health Carrier and a Domestic Insurer. Direct or Indirect Affiliates of Premera by New Premera Corp. September 17, 2003. This was also filed with the Alaska Division of Insurance and the Oregon Insurance Division. http://www.insurance.wa.gov/special/premera/filing.asp

[2] Navigant Consulting, "The Economic and Market Impact on Alaska of the Proposed Conversion of Premera Blue Cross to a For-Profit Entity." September 2003 Draft.

- Obtain a copy of the Accenture Study referenced in the business plan and review study for reasonableness of the items mentioned by Premera in the business plan.[3]
- Analyze current product pricing structure i.e., underpricing.[4]
- Assess whether reserves are adequate.
- Assess whether prospective rate increases are realistic and adequate.
- Assess whether prospective estimates of membership increases are reasonable without acquisitions or under pricing premium.
- Analyze estimates of cost to develop new products.
- Review current product mix profitability and compare with proposed product mix.
- Assess whether a conversion to for-profit status will reduce the need to increase premiums.
- Assess how for-profit status will affect providers.

Our Approach

To assess the likely effect of a conversion of Premera from not-for-profit to for-profit status we considered a number of issues, including the economic characteristics of Washington's healthcare market, other key economic characteristics of the State, current and future benefit designs and contracting strategies of Premera and other health insurers, and Premera's current and projected health care and administrative costs. We also reviewed other Blue Cross and Blue Shield mergers, acquisitions and conversions for lessons learned through those processes.

Background information for this report was obtained from numerous sources that include:

1. The Washington Office of the Insurance Commissioner
   - Statutory statements for health insurers
   - Interpretation of state regulations

[3] Accenture, "Community Impact Analysis of the Proposed Conversion of CareFirst, Inc. to a For Profit Business Entity and the Merger Between CareFirst, Inc. and Wellpoint Health Networks Inc.," January 2002.

[4] The term under pricing as used in the instructions to consultants is interpreted to mean premium rates lower than the amount needed to fully cover costs of a group. This definition is distinct from the economic term that would equate under pricing with rates lower than competitive circumstances would allow.

- Reports on changes in market position of health plans
- Reports on changes in pricing of health products

2. Premera Blue Cross
   - Financial Statements: Actual and projected by product line and business segment
   - Premium rates and rates of change over the past several years
   - Provider contracts and information on payment methods and fee schedules
   - Other documents as requested as part of the consultant review
3. Interviews with representatives of the health care industry
   - Staff of the Washington Office of the Insurance Commissioner
   - Competitor health plans
   - Physicians, physician group administrators, and hospital administrators
   - Brokers
   - Benefits staff of selected large employers
4. Publicly available information, including:
   - Federal Census and state demographic information
   - Reports of health care professional organizations

Review of Findings

The following section provides a summary of the report findings and highlights the evidence in support of these conclusions. It also addresses our response to questions and issues raised in the original consultant instructions and others that were added during the course of the engagement. More detailed analyses of each of these issues are presented in the body of our report.

Accenture Study

- The Economic Impact Analysis of the proposed conversion of Premera Blue Cross has addressed the major potential issues of a for-profit conversion of a health insurer that are raised in the Accenture study of the proposed conversion of CareFirst, Inc and merger with Wellpoint Health Networks.

Washington Demographic and Economic Characteristics

- Washington has higher average per capita income and higher rates of health insurance coverage than the national average. It also has a higher unemployment rate and population growth has slowed.

- The population of the state is concentrated in the western urban counties while the eastern counties are predominantly rural and more sparsely populated. The distribution of health care resources has a similar pattern.

- These characteristics imply that the market for health insurance will not significantly expand in the near future. New health plan enrollment growth is more likely to come from winning business from competitors, possible acquisitions, or development of new markets outside the State of Washington.

Washington Health Insurance Market

- Premera Blue Cross is the largest health insurer in the state. The most significant competitors are Regence Blue Shield of Washington, the second largest health plan, which competes directly in the western counties of the state and has a smaller presence with its non-Blue Asuris brand in the Eastern part of the state, and Group Health Cooperative, the third largest, an HMO that operates in the Seattle metropolitan area and in Spokane, the largest city in the eastern part of the state.

- The top three health plans cover 75% of the insured enrollees in the state, but the market share of the plans differs by line of business and geography. Premera and Regence Blue Shield are the leading insurers in individual and small group business, and have similar statewide market share. Large group business is more evenly split but also attracts national and regional health plans. In Western Washington, Premera is second to Regence; in Eastern Washington Premera is the dominant insurer as a result of business it acquired in the merger with Medical Services Corporation, a Blue Shield plan, in 1998.

Pricing Structure Adequacy

- Changes in operations and the health insurance environment in Washington have allowed Premera to return to profitability after years of losses in the mid-1990s. While financial results have improved, the company has not reached market-based target levels of operating margin in the aggregate; Premera has similarly failed to meet operating targets in specific lines of business.

- Given that most of the major lines of business in Washington have not attained market-based target operating margins Premera products appear to be priced below levels appropriate to cover costs and generate required capital. Based on actual results to date, overall operating margins will need to increase by 1% to 2% above current projections.

By line of service, some operating margins will need to improve from 2% to 5% to achieve target margins. The financial projection model suggests improvement in most lines of service, but results fall short of target operating margins.

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That presentation showed substantial changes in values that require additional time for analysis. Because there was insufficient time to assess the revised projections and to discuss the basis and reasonableness of the changes in the model with Premera management, we have not incorporated those values into our analysis. Further, Premera has indicated that the updated planning model is not to be considered a revision to the application for conversion.

Reserve Adequacy

- The external auditors review reserves at least annually. Reserves are analyzed by major business segment as well as for the company as a whole. PwC has reviewed Premera's reserve adequacy for 1997 through 2002. The process and controls are appropriate and although the year 1999 was deficient due to data problems caused by a systems conversion, the reserves over time have been adequate, and margins appear to be generally consistent and appropriate.

Projection Assumptions

- Premera Blue Cross' financial projection model relies on assumptions regarding health care cost trend, sales and general administrative cost trend, changes in enrollment, and allocation of expenses across lines of business to project operating margins. General assumptions on health care cost trend are reasonable.

- Premera may have to gain market share from competitors or new markets to meet Washington enrollment goals. To the extent that enrollment gains cannot be achieved in Washington, growth must be achieved in expansion markets.

- Analysis of the projection model identified inconsistencies in the expenses allocated through corporate financial reporting and the pricing and underwriting formulas used to price Premera's products. Resolution of the inconsistencies is a first step in properly analyzing profitability by product, and developing strategic measures related to growth initiatives. Achievement of target operating margins requires appropriate allocation of expenses.

- The results of the financial projection model of Premera Blue Cross do not meet the market-based expectation that most lines of business should attain target operating margins.

Options For Achieving Target Operating Margin

- Premera Blue Cross can adopt a mixture of strategies to improve target operating margins. It can increase revenue, reduce costs, or a combination of the two. The Premera projection model takes into consideration reductions in administrative and health care costs anticipated as a consequence of the roll-out of Dimensions; the projection model does not provide guidance on how further improvements would be made.

- It will be difficult for Premera to implement strategies to achieve the target operating margins given general economic and health care market conditions.

Prospective Rate Increases

- Premera's revenue growth goals will require increases in premiums and enrollment. Additionally, high performing stock companies consistently meet net operating margin goals in all lines of business. The operating results in Premera's projection model will not be adequate to generate the operating margins consistent with those expectations. To reach net operating margin targets Premera will need to either attain greater savings in health care costs or administrative expense or to increase premiums.

- Premera may be able to increase operating margins in geographic markets and lines of business where the company has dominant market share. This ability is largely limited to areas in Eastern Washington and to individual and small group lines of business. The Dimensions product may allow Premera to increase rates faster than health care trend for these members and remain within state rate setting regulations for these products. However, our models indicate that the ability to affect such changes is not likely to be sufficient to attain the target operating margins for all lines of business. Rate increases of as much as 8% to 10% above expected trend for some lines of business in some geographies will be required to meet Premera's goals.

- If Premera does not retain the preferential Federal tax treatment for Blue Cross and Blue Shield plans, the effective corporate tax rate would increase from 20% to at least 35%.

Cost to Develop New Products

- Most of the effort and cost to develop the Dimensions product for the Washington market has already been incurred and is a significant factor in the cost projections. The costs in the projection model include the last years of FACET information system sale-lease back.

Product Mix and Profitability

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- Premera currently participates in Healthy Options, the state Medicaid managed care program, and the Washington Basic Health Plan, a state subsidized insurance program for other low-income individuals and families. [PROPRIETARY MATERIAL REDACTED] As a for-profit company, Premera would have greater incentive to exit these programs if financial performance deteriorates. The company has announced withdrawal from the state government PEBB account effective January 2004.

Provider Contracting and Payment Levels

- Premera has one of the largest PPO provider networks in the state of Washington. The Foundation network for the Dimensions product reduces contracted network size, but maintains contracts with 79% of the current PPO providers and 92% of the hospitals. The Heritage network of Dimensions contracts with a provider network that is comparable to the current PPO network.

- There is evidence that Premera has used its market power to achieve lower contracted provider prices in Eastern Washington. Premera's ability to drive provider fee levels in Eastern Washington is not expected to be reduced as a consequence of the conversion. There may be greater pressure to reduce fees (or increase fees at a slower pace) to meet operating margin goals.

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For small group products, the Dimensions product appears to have achieved lower costs and increased the differential between the geographic area cost factors for Western and Eastern Washington.

For large group products, the relationship between Western and Eastern geographic area cost factors appears to be similar to that of its current products, but the anticipated dollar premium level is expected to move employer groups to Dimensions products with lower network costs.

Conclusions

[PROPRIETARY MATERIAL REDACTED]5 Premera's performance to date and future projections are weaker than those of comparable companies. In addition, Premera is untested as a public company. Taken together, Premera's Initial Public Offering (IPO) price will likely be lower than that of its peers. Improved performance will be necessary to enhance Premera's stock value. Premera's operating costs are above the average for its peer group, and the Dimensions product is expected to reduce those levels. These administrative cost improvements are built into Premera's projection models.

Given the current and projected financial position of Premera, it is not likely that the conversion to a for-profit company will provide both maximum value to the public through establishment of a foundation and protection of the members and providers that do business with the company.

If Premera implements strategies to achieve target margins, it will help to assure maximum value of the stock price and increase the assets of the proposed foundation but may have negative consequences for members and providers. If the company maintains the current plan, members and providers may be protected, but the stock valuation would be depressed relative to other for profit health plans and a foundation would not receive the maximum value.

Premera dominates the insurance market in Eastern Washington, with some limited exceptions. Its Dimension product design may allow it to take greater opportunity of its market power in that area, particularly in the individual and small group markets. Premera is one of several carriers operating in Western Washington and is restricted in its ability to increase premiums in those areas.

Premera's market dominance affects its relations with providers, with Eastern Washington providers receiving generally lower payment amounts and reporting a greater level of unhappiness with Premera than those in Western Washington. Geographic area rating factors suggest provider network payments are [ ]% to [ ]% lower in Eastern Washington for the current Premera products and that the difference may increase to [ ]% to [ ]% under the

5 Corporate projections for 2007. See Table 7-12.

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PROPRIETARY MATERIAL REDACTED] Providers in that geographic area have limited choice regarding participating in Premera networks. These circumstances will be unchanged following a conversion, while pressure to meet financial performance goals will be heightened, putting added pressure on provider relations.

Premera has traditionally participated in public programs (Healthy Options and the Basic Health Plan) and states that it assesses its participation on an annual basis. [

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To the extent that Premera requires additional capital, it may provide Premera the opportunity to expand into new areas. Given current market share, Premera's growth opportunities are limited to winning business from competitors or growth of new markets. Consequently, the capital may be used in large part to allow Premera to grow outside of the State of Washington.

Premera's expense allocation formulas appear to result in subsidization of some business lines. As a public company Premera would be expected to reach target operating margins over time in each business line independently. [

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] It is unlikely that Premera can achieve its growth and pricing goals simultaneously.

1. BACKGROUND

Purpose of the Report

On September 17, 2002, Premera Blue Cross filed a Form A application to the Washington Office of the Insurance Commissioner to convert from a non-profit health services contractor to a for profit publicly traded health insurer with the proceeds from Washington's share of the value of the company used to fund a foundation to address health care issues for the State of Washington.

Premera and its affiliated companies are currently organized as a Washington non-profit corporation. Premera's affiliated companies include both non-profit and for-profit companies that maintain operations in the states of Washington, Alaska, Oregon, and Idaho. Premera Blue Cross is licensed as a health care service contractor under Section 48.44 of the Revised Code of Washington (RCW) and as a hospital and medical service corporation under Section 21 of the Alaska Statutes (AS).

Prior to approving or disapproving the proposed conversion, the Washington Office of the Insurance Commissioner (WA OIC) is required to hold hearings. During the hearings, OIC staff and experts will present information and recommendations regarding the transaction. Premera Blue Cross will also present information and recommendations. This report on the potential market impact of the transaction in the State of Washington has been prepared for the Washington Office of the Insurance Commissioner as background for these proceedings. A separate report has been prepared on the potential market impact of the transaction in the State of Alaska.[6]

Criteria for Approval of the Conversion of Premera Blue Cross of Washington

Under Washington State law, both the Insurance Commissioner and the Attorney General have a role in reviewing and recommending approval/disapproval of the transaction. As

[6] Navigant Consulting. The Economic and Market Impact on Alaska of the Proposed Conversion of Premera Blue Cross to a For-Profit Entity. September 2003 Draft Report.

outlined in a memo prepared by the Washington Office of the Attorney General, these "roles are complementary, and in certain respects, overlapping."[7]

The fundamental framework for the review is established in the Insurer Holding Company Act (IHCA) Chapter 48.31B RCW, and the Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations (HHCA), Chapter 48.31C RCW. Under these Holding Company Acts the Commissioner of Insurance must approve the application unless it is determined that:

1. After the conversion the for-profit company would not satisfy the requirements for registration as a health carrier;
2. The effect of the transaction will substantially lessen competition or tend to create a monopoly in the health coverage business;[8]
3. The financial condition of the for-profit entity might prejudice the interests of the subscribers;
4. The business plan of the for-profit company is unfair and unreasonable to subscribers and not in the public interest;
5. The proposed management of the for-profit company lacks competence; and
6. The conversion is likely to be hazardous or prejudicial to the insurance buying public.

If the Commissioner does not find in the company's favor regarding each of the criteria, the application for conversion may be disapproved, or it may be approved on the condition that the reason for disapproval is removed or corrected within a specified period of time.

Separate review of the transaction will occur in Alaska and Oregon, the other states in which Premera operates. The Washington Office of the Insurance Commissioner remains the lead agency as the regulatory body in the state with the company corporate headquarters.

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[7] Holding Company Act and memorandum dated October 15, 2002 to Christine O. Gregoire, Attorney General, from David Walsh, Deputy Attorney General and staff, Office of the Attorney General of Washington, Olympia, WA. As available at http://www.insurance.wa.gov/ under Premera Conversion Issues.

[8] The antitrust section of the Office of the Attorney General is providing input on this issue.

Focus and Structure of Report

The Washington Office of the Insurance Commissioner engaged a team of consultants to advise on whether the Plan of Conversion, as submitted in the required Form A and supporting documents, meets these criteria. Other consultant advisors, including outside counsel, investment bankers, and separate teams from PricewaterhouseCoopers, have developed reports that address whether aspects of these conditions have been met.

The Economic Impact Analysis specifically focuses on analysis that is pertinent to evaluate three of the criteria in the Holding Company Act:

1. The financial condition of the for-profit entity might prejudice the interests of the subscribers;

2. The business plan of the for-profit company is unfair and unreasonable to subscribers and not in the public interest;

3. The conversion is likely to be hazardous or prejudicial to the insurance buying public.

These criteria subsume pertinent questions such as the current financial condition and business practices of Premera Blue Cross and whether the business plan and projections are realistic and adequate. It also addresses whether the changes in financial condition and business practices that are possible or expected as a result of conversion from a non-profit to a for-profit company are different and separate from changes that can be reasonably explained by health care market conditions facing all health insurers in the State of Washington.

2. DESCRIPTION OF PREMERA BLUE CROSS

Corporate History of Premera Blue Cross

The antecedents of Premera Blue Cross date to the formation of the first hospital and medical association plans in Washington and Alaska. The company operates throughout both of those states and, through an affiliate, has expanded operations into Oregon. LifeWise Health Plan of Oregon has a license to operate in Idaho but does not currently market products in that State. Premera recently obtained a license to operate in Arizona under an affiliate, LifeWise of Arizona.

Although the predecessor organization dates back to 1933, the Washington Hospital Service was legally incorporated in May 1945 and issued a certificate as a health care service contractor in July 1948. The Alaska plan was authorized as a hospital and medical services corporation in that state in May 1952. The two plans joined in 1957, but operated under separate names until amended articles of incorporation changed the name to Blue Cross of Washington-Alaska, Inc. in March 1969. A for-profit subsidiary, Washington-Alaska Group Services, was incorporated in 1975 as an agent for insurers and a few years later, the plan was renamed Blue Cross of Washington and Alaska.

Blue Cross of Washington and Alaska began development of a network model HMO, HealthPlus, in the early 1980s and acquired Chelan County Medical Services Corporation in 1985. The company acquired Pacific Health and Life Insurance Company in 1994, and renamed the for-profit subsidiary LifeWise Health Plan of Oregon. In 1994, it approved affiliation with Medical Service Corporation (MSC) of Eastern Washington, the plan that held the Blue Shield service mark for most of the eastern counties, and a merger of the programs was completed in June 1998. At the time of the merger, the corporate name was changed to Premera Blue Cross. In December 2000, the HMO plan, Premera HealthPlus was formally merged into Premera Blue Cross, and LifeWise Health Plan of Washington was formed in 2001. The timing of significant events for the corporate body, the health insurance business, and selected subsidiary transactions are presented in Table 2-1.

Table 2-1
Timeline of Significant Premera Blue Cross Transactions

Date	Transaction/Purpose
May 9, 1945	Formation of WASHINGTON HOSPITAL SERVICE ASSOCIATION.
July 8, 1948	Authority to operate as a health care service contractor in the State of Washington.
May 28, 1952	Authority to transact insurance as a hospital and medical service corporation.
March 24, 1969	Change name to BLUE CROSS OF WASHINGTON-ALASKA, INC.
June 13, 1975 September 26, 1975	Authority to incorporate a new Washington business-for-profit subsidiary WAGS (WASHINGTON-ALASKA GROUP SERVICES, INC.)
April 11, 1978	Change name to BLUE CROSS OF WASHINGTON AND ALASKA,
September 12, 1980	Approve development of a Plan sponsored network model HMO (formation of HEALTHPLUS).
March 17, 1981 July 23, 1981	Formation of WASHINGTON AND ALASKA HEALTH NETWORKS. Change name to HEALTHPLUS
December 13, 1985	Approve acquisition of CHELAN COUNTY MEDICAL SERVICE CORPORATION.
May 6, 1987	Authority to transact business as a health care service contractor in the State of Washington.
July 15, 1993	Approve acquisition of LIFEWISE HEALTH PLAN OF OREGON, FORMERLY PACIFIC HEALTH AND LIFE INSURANCE COMPANY.
October 19, 1994.	Approve affiliation with MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON and formation of PREMERA.
February 27, 1995	Authority to transact business in Alaska as BLUE CROSS OF WASHINGTON AND ALASKA.
March 10, 1995	Authority to transact business in the State of Idaho as BLUE CROSS OF WASHINGTON AND ALASKA.
July 2, 1997	Change name of LIFEWISE OREGON to LIFEWISE, A PREMERA HEALTH PLAN, INC.
June 30, 1998	Merger of MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON into BLUE CROSS OF WASHINGTON AND ALASKA.
June 30, 1998	Change name to PREMERA BLUE CROSS.
July 30, 1998	Authority to transact health insurance business in Alaska as PREMERA BLUE CROSS.
August 12, 1998	Authority to form LIFEWISE HEALTH PLAN OF WASHINGTON, formerly PREMERA HEALTHCARE, INC.

Table 2-1 (cont.)
Timeline of Significant Premera Blue Cross Transactions

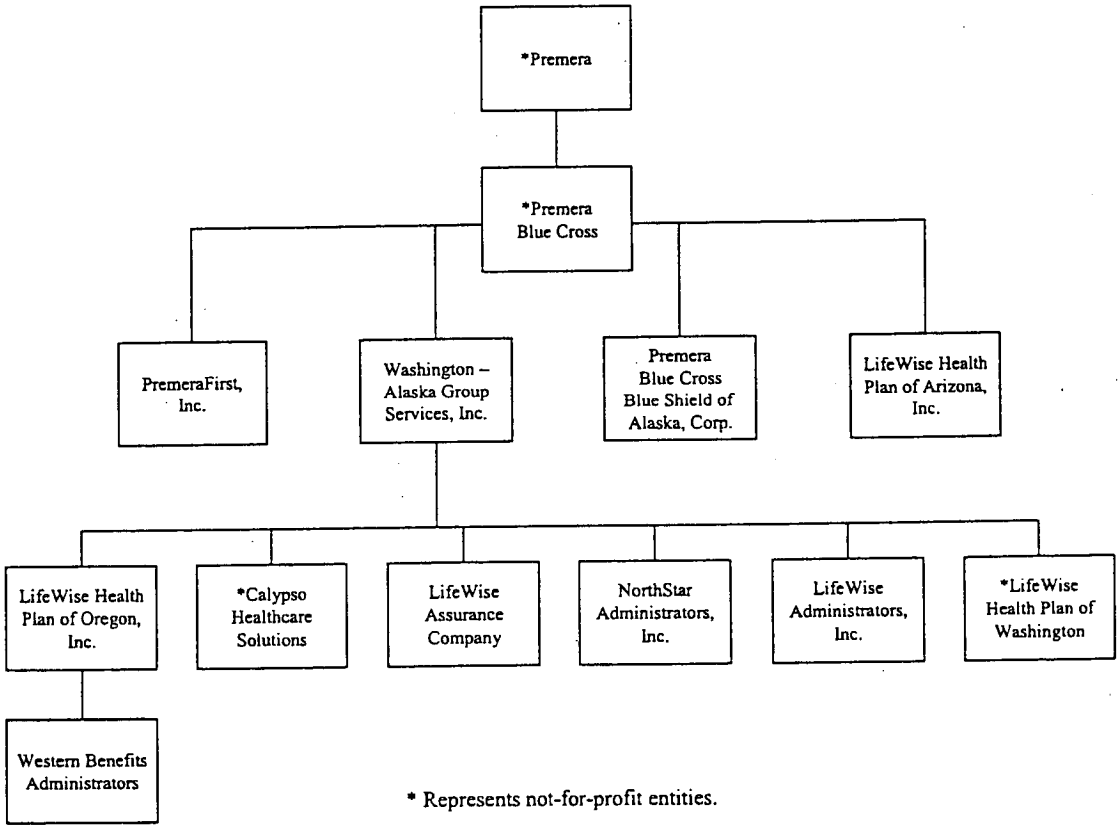
Date	Transaction/Purpose
November 8, 1998	Authority to transact business in Alaska as PREMERA BLUE CROSS d/b/a PREMERA BLUE CROSS BLUE SHIELD OF ALASKA.
November 19, 1998	Formation of PREMERA HEALTH CARE, INC., a profit corporation, predecessor to LIFEWISE WASHINGTON
June 24, 1999	Authority to transact business in the State of Idaho as PREMERA BLUE CROSS d/b/a PREMERA BLUE CROSS, A NONPROFIT CORPORATION.
December 1, 1999	Authority to form Quality Solutions.
January 21, 2000	Authority to merge MSC SERVICE CORPORATION into WASHINGTON-ALASKA GROUP SERVICES, INC.
January 27, 2000	Merger of MSC SERVICE CORPORATION into WASHINGTON-ALASKA GROUP SERVICES, INC.
August 31, 2000	Authority to operate PREMERA HEALTHCARE as a health care service contractor in the State of Washington.
December 22, 2000	Merger of PREMERA HEALTHPLUS into PREMERA BLUE CROSS.
July 11, 2002	Change name of PREMERA HEALTHCARE to PREMERA LIFEWISE HEALTH PLAN OF WASHINGTON.

Source: Premera Bates Range 0029827 to 0029844

Organizational Structure of Premera

Premera, a Washington based non-profit holding company, owns and operates Premera Blue Cross. Premera Blue Cross is licensed as a Washington non-profit health care service contractor (HCSC). Subsidiaries of Premera Blue Cross include both non-profit and for-profit corporations as depicted in the organizational chart in Figure 2-1.

Figure 2-1
Premera Corporate Organization Chart



* Represents not-for-profit entities.

Organizational chart is current through September 3, 2003.

Major subsidiaries of Premera Blue Cross include PremeraFirst, Inc., Washington-Alaska Groups Services (WAGS), Premera Blue Cross Blue Shield of Alaska (and LifeWise Health Plan of Arizona (formerly MSC Life insurance Company). PremeraFirst, Inc. was formed in 1989 and has authority to operate in Washington, Alaska and Oregon as the primary agent for contracting with physicians and other providers. LifeWise Assurance Company is licensed

to transact life and disability insurance in Washington. LifeWise Health Plan of Arizona, formerly MSC Life Insurance Company, is licensed as a for-profit and was recently approved to transact life and disability insurance business in Arizona. Premera Blue Cross Blue Shield of Alaska is a for-profit that will seek authorization to sell health insurance in that state.

WAGS is a for-profit insurance company that owns LifeWise Health Plan of Oregon, LifeWise Health Plan of Washington, Calypso Healthcare Solutions, LifeWise Assurance Company, NorthStar Administrators, Inc., and LifeWise Administrators, Inc. The LifeWise Health Plans of Oregon and Washington, LifeWise Assurance Company, and NorthStar are for-profit companies. Calypso, formerly Quality Solutions, is a not-for-profit company formed in 2000 as a consulting firm to assist firms in claims and trends analysis to identify opportunities for reducing health care costs.

Operations of Premera Blue Cross

Premera Blue Cross is headquartered in Mountlake Terrace, Washington and maintains operations in Seattle and Spokane, Washington, in Anchorage, Alaska, Portland and Bend, Oregon, and Scottsdale Arizona. The company employs 3,200 people across these locations.

Premera Blue Cross Products

Premera Blue Cross offers a range of medical and specialty health care products, including Preferred Provider Organization (PPO), Point of Service (POS), Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), traditional indemnity coverage, and vision and dental plans. The company also sells Medicare Supplement coverage, long-term care insurance, and administers medical savings accounts. It participates in programs for low-income populations in the state of Washington, including the Medicaid managed care program, Healthy Options, and the Washington Basic Health Plan.

The predominant product type is PPO, with a small volume of POS. The membership in HMO products and traditional indemnity is declining. Table 2-2, which reports enrollment in both Washington and Alaska, shows enrollment by product type as reported in the Annual Statements filed with the Office of the Insurance Commissioner. PPO increased from 65% to 73% of the members between 2000 and 2002, while HMO decreased from 24% of membership to 17%.

Table 2-2
Premera Blue Cross and LifeWise Health Plan of Washington
Enrollment by Product Type

	2000	2001	2002	% Distribution 2002
HMO	237,153	205,979	159,488	16.9%
PPO	641,884	677,668	687,849	72.7%
POS	17,776	22,116	22,808	2.4%
Indemnity only	84,849	80,967	75,492	8.0%
Total	981,662	986,730	945,637	100.0%

Source: NAIC Annual Statement to the State of Washington, 2001 and 2002
Premera Blue Cross enrollment includes both Washington and Alaska. LifeWise Health Plan of Washington is reported in a separate filing.

Commercial Products

Premera re-entered the Washington individual insurance market in late 2000 as both Premera Blue Cross and LifeWise Health Plan of Washington after passage of reform legislation modified regulations for coverage and underwriting guidelines in this market.[9] The company has an older book of individual business that it renews through Premera Blue Cross, which was closed to new members in November 1998 after Premera experienced adverse selection and large financial losses [10].

The company offers Prudent Buyer PPO and traditional plans to the Individual market, with three benefit options that vary primarily in dollar or percentage coverage and the level of deductibles.

In the group market, the company sells PPO, Traditional and HMO products, and has recently introduced a new product, Dimensions. The traditional and Prudent Buyer PPO products are available statewide. HealthPlus, the HMO product, is offered primarily in Western Washington. In the 14 eastern counties where MSC operated, Premera offers a

[9] 2SSB6067, passed in March 2000, reintroduced medical underwriting in the individual market, extended the waiting period for pre-existing conditions to 9 months, allowed carriers to set rates subject to a 72% medical loss ratio or contribution to the Washington State High Risk Pool, and permitted catastrophic policies that did not mandate coverage for maternity or prescription drugs.

[10] Legislature Returns, and So Does Health Care Battle. Seattle Post Intelligence, January 9, 1999 and State's Health Insurance Crisis deepens as Regence, Group Health Pull the Plug. Seattle Post Intelligence, September 1, 1999. At the time Premera had approximately 125,000 individual members and represented 60% of the private individual market. Both Regence Blue Shield and Group Health froze individual enrollment in September 1999.

second traditional and Preferred PPO product that builds upon the MSC network and benefit design. At present, the majority of the company group business is in the PPO products.

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The Dimensions product is built around four networks that reflect different levels of provider efficiency and cost and which permit many options for levels of co-payment and deductible.

The Foundation network, the base plan, offers a mid-size network with 85 hospitals and over 13,300, or almost 79% of the physicians in the state. The Access network is a larger network with approximately 13,400 providers that includes the Foundation network. Heritage is the largest contracted network. It has contracts with over 16,000 physicians and other providers, including all providers in the Foundation and Access networks, and is essentially comparable to the current PPO product network. The fourth tier, the global network, provides access to all licensed providers in the state.

Each network can be a stand-alone product, or it can be combined with out-of-network benefits through a second tier called the Dimensions Plus 1 products. These products offer more benefits and coverage when members use providers and hospitals in the core network, and have a reduced level of coverage when using the Plus network.

Because of the limited number of hospitals and physicians in some geographic areas of the state there is limited opportunity to tier networks, establish a statewide product and still meet regulatory requirements of network adequacy. For these areas, primarily the rural areas and smaller cities with less provider competition, the Foundation network includes most providers and there is little difference in the contracted provider network among the tiers.

The Dimensions roll-out began in 2002 and is being marketed to new accounts and as a replacement product to existing accounts. It was available to mid-size groups (51-99 employees) throughout the state and to large groups (100+ employees) in Western Washington at the beginning of the year. It became available to small groups (1-50 employees) mid-year.

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Participation in Public Programs

Premera has accounts with a number of public programs, including Federal and State employee health benefits and those for low income populations, including Healthy Options, the Medicaid managed care program and the State Child Health Insurance Program (CHIP) for children under 19, and the Basic Health Plan (BHP), the expansion program for low income populations who do not qualify for the Medicaid or CHIP public insurance programs. Overall, the target operating margin for government related business is assumed to be breakeven.

Federal Employees Program

Premera participates in the Federal Employees Program (FEP) through the national Blue Cross Blue Shield Association. The projection model assumes continued participation in FEP, with slight increases in enrollment over the time period.

State Public Employees Benefits Board

The Washington State Health Care Authority conducts a bid process for health plans that are interested in participating in the State Public employees Benefits Board (PEBB) program. At present, the HCA contracts with seven plans[11] and offers a self-insured Uniform Medical Plan. Premera has participated in PEBB for at least the past five years, but withdrew from PEBB for the 1998 plan year.[12] As of January 2003, the Premera Dimensions Foundation product replaced the PPO product offered to the state employees. Premera has subsequently withdrawn from the program for 2004. As of June 2003, the Premera Foundation plan enrolls nearly 42,000 members, including 4,000 retirees and represents 13.5% of the total PEBB membership of 308,000. The two Group Health products and the Uniform Medical Plan have the largest market shares. Group Health enrolls 100,900 members, or 32.8% of the total and UMP enrolls 97,700 members, nearly 31.7% of the total.[13]

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[11] The plans are Group Health Cooperative, Group Health Options, Kaiser Foundation Health Plan of the Northwest, PacifiCare of Washington, Premera Blue Cross, and Regence Care. Community Health Plan of Washington was frozen to new enrollment effective January 1, 2003. PEBB also offers two Medicare Supplemental benefits packages. Washington State Health Care Authority PEBB Employee Enrollment Guide, Effective January 2003.

[12] Washington State Health Care Authority, 1997 Annual Report to the Legislature, January 1998 and 1998 Annual Report to the Legislature, May 1999. At http://www.hca.wa.gov/annualreport/97annual.pdf and http://www.hca.wa.gov/annualreport/98annual.pdf

[13] Washington State Health Care Authority, PEBB Enrollment Report for June 2003 Coverage, Total Member Summary. http://www.pebb.hca.wa.gov/enrollment/Jun2003.pdf

Medicare

Premera announced withdrawal from the Medicare managed care market in early 2000 for its HealthPlus Medicare+Choice HMO product, a period when other health Washington insurers also dropped participation in the program.[14] It withdrew the Classic Care Medicare+Choice product at the end of 2001. Today, only three plans, Group Health Cooperative, Kaiser, and PacifiCare, offer a Medicare+Choice product and enrollment is concentrated in the Seattle metro area, Clark and Cowlitz counties and Skagit, all in Western Washington.

Premera continues to sell Medicare Supplemental fee-for-service insurance products.

Healthy Options and Children's Health Insurance Program

Premera is one of seven health plans that participate in Healthy Options (HO) and the Children's Health Insurance Program (CHIP) in Washington. Three of the plans, Community Health Plan of Washington, Molina, and Columbia United Providers [15] primarily serve Medicaid and CHIP eligibles and do not have significant commercial insurance enrollment. These three plans enroll nearly 60% of the 466,642 beneficiaries enrolled in the Healthy Options and CHIP program as of August 2003.[16]

Premera has HO and CHIP enrollees in ten counties, with its greatest enrollment in King, Pierce, and Whatcom counties in the western part of the state. The largest enrollment in the eastern counties is 1,843 members in Yakima. Overall, Premera enrolled approximately 41,000 HO and CHIP members in August 2003. This is slightly more than the 36,000 enrollees in Regence and its non-Blue affiliate, Asuris NorthWest Health and more than the approximately 31,000 enrolled through Group Health.

Basic Health Plan

The Basic Health Plan (BHP) provides insurance coverage to low-income families in the state who are not eligible for Medicaid and who meet the program income guidelines. The program is administered through a choice between a private health plan and the state fee for

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[14] Regence announced withdrawal of its RegenceCare HealthSense product for seniors in July 2000, effective January 2001. First CHOICE and Aetna also withdrew from the Medicare+Choice product around the same time.

[15] CHPW is a non-profit health plan that was established in 1992 by a network of community and migrant health centers. Molina, based in California has Medicaid plans in California, Michigan, Utah and Washington. It held an initial public offering in July 2003.

[16] The majority of this enrollment is in CHPW and Molina. Columbia enrollment was 114,365 (24%) and Molina enrollment was 165,209 (35%) as of August 2003. Medical Assistance Administration, Department of Social and Health Services, State of Washington. Healthy Options Enrollees, Plan by County and County by Plan, August 2003. http://fortress.wa.gov/dshs/maa/HealthyOptions/pdffiles/0803/Aug03planxcounty.pdf

service program in most counties throughout the state.[17] Monthly premiums are based on family size, income, age, and the health plan selected. The state pays a portion of the monthly premium of those who qualify. The member pays a sliding scale contribution to premium, which may be as low as $10 per month for each enrolled adult. Although co-payments are required for most services, there are no deductibles or coinsurance.

Children in the BHP families who are not eligible for Healthy Options may be eligible for Basic Health Plus. This program offers children a wider range of benefits, including dental and vision care, with no additional premiums or co-payments.

Currently, eight health plans participate in the BHP. Not all health plans are offered in all counties and some counties do not have any BHP health plans. Premera participates in the Basic Health Plan in 11 counties and enrolled approximately 25,400 members at the end of 2002.

[17] Community Health Plan of Washington offers coverage in 31 of the 39 counties.

3. DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF WASHINGTON

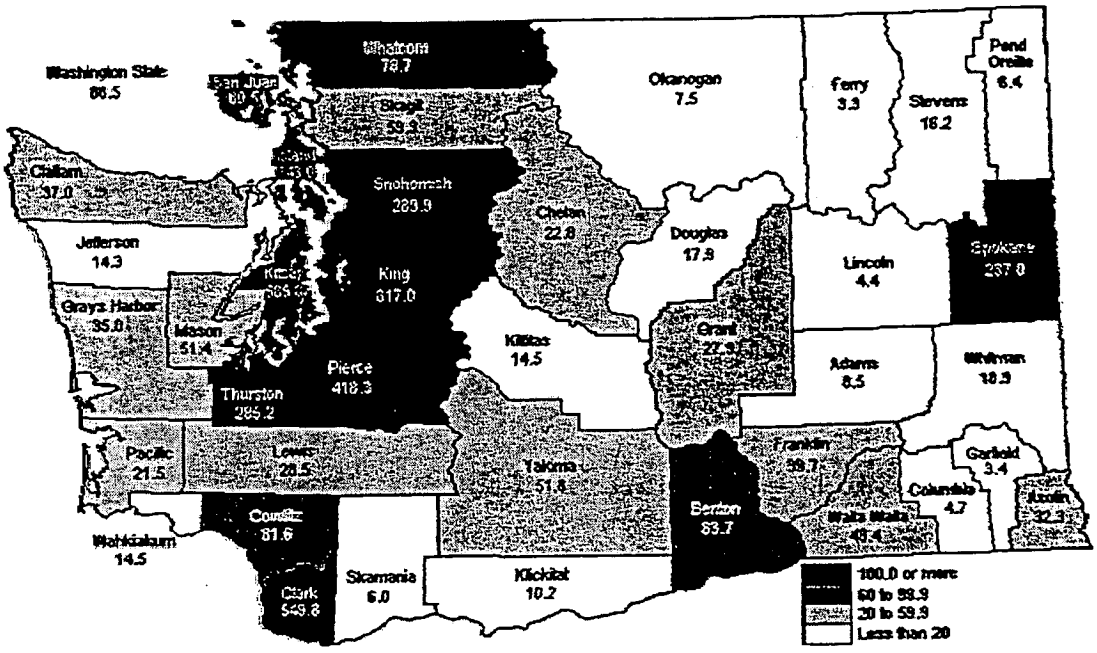
This section discusses the demographic and economic characteristics of the State of Washington and compares these statistics to the United States average. Data is taken from the 2000 Census, the Census 2000 Supplementary Survey, and recent special surveys conducted by the United States Census Bureau. Additional information is from Washington state agencies and from national and state professional associations such as the American Medical Association or the Washington State Hospital Association.

Demographic Characteristics

The state of Washington is located in the uppermost corner of the Pacific Northwest and is bounded on the north by the Canadian province of British Columbia, to the east by the state of Idaho, and to the south by Oregon. The population of 6 million is concentrated in the Western counties along the Pacific Ocean, particularly in the urban corridor surrounding Seattle that stretches south towards the capital of Olympia. This consolidated metropolitan area has an estimated 3.6 million people; of that, almost 1.8 million are in Seattle and the remainder of King County. Clark County, bordering Portland, Oregon, has a population of about 360,000

The Eastern counties, generally defined as those east of the Cascade mountain range, include more than half of the land area but only 22% of the population. The major urban center, Spokane, is a metropolitan area of 425,000 that is on the eastern state border and 40 miles from Coeur D'Alene, Idaho. Other urban areas in the eastern part of the state are Yakima, with a county population approaching 225,000 and the Tri-Cities of Richland-Kennewick-Pasco in Benton and Franklin counties with slightly less than 200,000 population. The metropolitan counties of the state had the highest population densities. King County, at the top had a population density of 817.0 people per square mile, followed by Kitsap at 585.8 and Clark and 549.8. At the other extreme, Columbia, Lincoln, Garfield, and Ferry Counties all had population densities less than 5.0 persons per square mile. A map of the Washington counties showing population density is shown in Figure 3-1.

Figure 3-1
Washington State - US Census 2000
Persons per Square Mile



Source: *http://www.ofm.wa.gov/census2000/pl/maps/map03.htm*

Population growth since the 2000 Census has been about 1 percent per year, and dropped to a twenty year low of 0.9% annual growth between April 2002 and April 2003. A number of large counties, including King and Spokane, grew at a lower rate. As of April 2003, Washington population is estimated to be 6,098,300.[18] Current projections assume that these low growth rates will continue until the economy improves.

Economic Characteristics

Household and per capita income in Washington are higher than national averages. Median household income in Washington is 9% higher at $45,776 versus the national median of $41,994. Per capita income is $22,973, compared to the national average of $21,587.

[18] Washington State Office of Financial Management. April 1 Population of Cities, Towns and Counties 2000-2003.

Annual average pay is $57,172 for Washington and $56,604 nationally. As would be expected with higher average income, the percent of persons in poverty is below the national average. An estimated 13.3%[19] of all Washingtonians and 13.2%[20] of children live in poverty. This compares to national estimates of 15.5% percent of persons in poverty and 16.1% of children. Consistent with this, 68.4%[21] of Washingtonians are above 200% of the Federal Poverty Level compared to 65.9% nationally.

More current data might show some change in the income figures. As of May 2003, the Washington unemployment rate is 7.4%, substantially above the national average at 5.8%. Compared to the prior year, Washington state unemployment has increased slightly while the national unemployment rate has begun to decrease.[22]

The high unemployment rate, in combination with a low rate of population growth suggest that the commercial health insurance market in Washington may not grow substantially over the next few years.

Medical Expenditures and Health Insurance Coverage

Health care expenditures in Washington range around the national average when measured on both a cost per unit and per capita basis. Geographic weighting factors developed for Medicare inpatient hospital and physician payments vary around the national average. Hospital DRG weights range from 1.3% to 10.6% above the national average. The physician Resource Based Relative Value Scale (RBRVS) King County factor is approximately 1.05, indicating a professional cost basis that is 5% above the national average while the rest of the state has a factor of .97 or 3% below the national average.[23]

Per capita annual health expenditure measures are lower. Personal health care expenditures per capita are $3,382, more than 10% below the national average of $3,759. A significant portion of this difference is explained by lower hospital spending. Hospital expenditures per

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19 Kaiser State Facts using Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys. Total U.S. numbers are based on March 2001 estimates.

20 Most of the information provided in this section is from the U.S. Bureau of the Census, Census 2000.

21 Kaiser State Facts using Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys. Total U.S. numbers are based on March 2001 estimates.

22 Kaiser State Facts using: Bureau of Labor Statistics, Regional and State Employment and Unemployment (Monthly) data, Table 3: Civilian Labor Force and Unemployment by State and Selected Areas, Seasonally Adjusted, 2002 and 2003, based on data from the Current Population Survey, available at http://www.bls.gov/news.release/laus.t03.htm. National data from Bureau of Labor Statistics, Current Population Survey, Most Requested Statistics, available at http://data.bls.gov/cgi-bin/surveymost?ln

23 The RBRVS geographic practice factors are weighted by the Medicare average RVU distribution as reported by the Medicare Payment Advisory Commission.

capita are approximately 20% lower, $1,116 compared to $1,405 per person, and physician expenditures are 5% lower, $1,037 compared to the US average of $1,095.[24] In comparison, adjusted hospital expenses per inpatient day are 39% higher than the national average, $1,595 in Washington compared to $1,149 nationally.[25] It appears that a major reason for the lower expenditure is not the unit cost of services but utilization patterns that are below the national average.

The proportion of Washingtonians with some form of health insurance is greater than the national average. The estimate for 2001 is that 87% of the Washington population had private or government sponsored insurance compared to 85% for the population of the United States.

The percent covered through private health insurance, both group and individual, is very close to the national average. For both Washington state and the national population, 58% are estimated to have employer based insurance; 6% in Washington have individual coverage compared to 5% nationally. Medicaid and the State Child Health Insurance program cover 11% of the Washington population, the same as the national average. And 12% in Washington have Medicare coverage compared to 12% nationally.

Information prepared for the Washington State Office of the Insurance Commissioner updates the information to 2002 and provides a more detailed breakdown of sources of health insurance coverage. Using information from public agencies, carrier filings with the OIC and results from the Washington State Population Survey 2002, the Washington Health Care Task Force reported that 89.3% have a source of private or public insurance and 10.7% remain uninsured. Among those with insurance coverage, 54.5% have private insurance and public programs, including Medicare, Medicaid, public employees and the military, cover 45.5%. Among the nearly 3 million privately insured, approximately 1.7 million are covered by private insurance, 1.2 million are in self-funded plans, with the remainder in other programs. These results are presented in Table 3-1.

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24 State Health Expenditures, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, September 2002. Available at http://www.cms.hhs.gov/statistics/nhe/state-estimates-residence.

25 2001 AHA Annual Survey. Copyright 2003 by Health Forum LLC, an affiliate of the American Hospital Association, available at http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=637&cartID=173831

Table 3-1
Washington State
Insured Population by Financial Source, 2002

	Est. #	% Total	% Insured
Private insurance	**2,937,600**	**48.6%**	**54.5%**
Health plans	1,654,200		30.7%
Self-insured firm	1,159,300		21.5%
Other	124,100		2.3%
Public insurance	**2,456,800**	**40.7%**	**45.5%**
Public employees	860,400		16.0%
Medicare	733,300		13.6%
Medicaid	739,000		13.7%
Basic health	124,100		2.3%
Insured	**5,394,400**	**89.3%**	**100.0%**
Uninsured	**648,200**	**10.7%**	
Total	**6,042,600**	**100.0%**	

Source: Health Insurance Market in Washington State: Current Status and Trends. Prepared by Washington State Office of the Insurance Commissioner.

The same study reported estimates of differences in the extent of insured, uninsured and general category of coverage by geographic region. In general, the major urban areas of Clark, King, the Puget Metro Area and Spokane were at or above the state average while the rural areas in both western and eastern regions showed lower levels of employment based insurance and higher levels of the uninsured. This is presented in Table 3-2.

Table 3-2 Washington State Insured and Uninsured by Region, 2002			
	Employment Based	Non-Employment Based	Uninsured
State	64.2%	25.1%	10.7%
Clark	72.5%	19.2%	8.3%
King	70.5%	20.3%	9.2%
Other Puget metro	66.6%	24.0%	9.4%
North Puget	52.6%	32.8%	14.6%
Rest of West	57.1%	28.7%	14.2%
Spokane	63.4%	26.4%	10.2%
Tri-Cities	57.0%	28.8%	14.2%
Rest of East	47.7%	37.7%	14.6%
Source: Health Insurance Market in Washington State: Current Status and Trends. Prepared by Washington State Office of the Insurance Commissioner.			

Hospital Market in Washington

Hospital resources and utilization are lower than the national averages. There are 1.9 staffed beds per 1,000 in short-term general hospitals in Washington. For the United States, there are 2.9 staffed beds per 1,000. Washington has 87 inpatient hospital admissions per 1,000 compared to the national average of 119 per 1,000.

As is common in places with both urban centers and large rural areas, hospital resources are not distributed evenly throughout the state. There are 91 acute care hospitals in the state, but four of the 39 counties have no community hospital and another 14 have only one hospital. Because the population in these counties is small, statistics on beds per 1,000 do not completely capture this disparity, but residents of counties with a single facility may have to travel substantial distances for care and may need to cross county boundaries for specialty care. All of the counties with urban population centers show bed per 1,000 ratios above the state and national averages.

Figure 3-2
Washington State - Available Beds per Hundred Thousand
Acute Care Hospitals

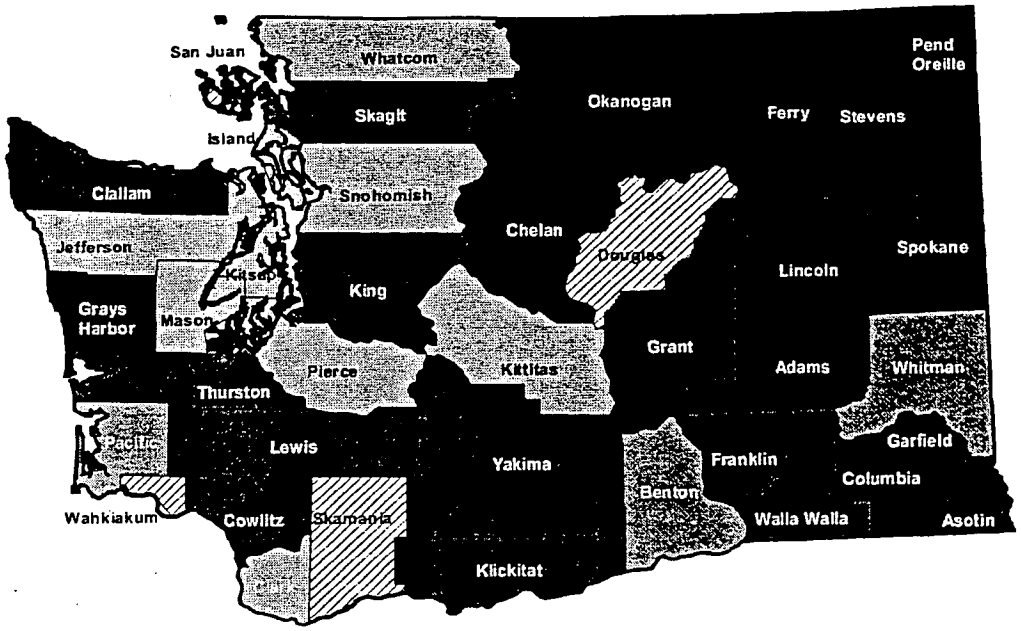
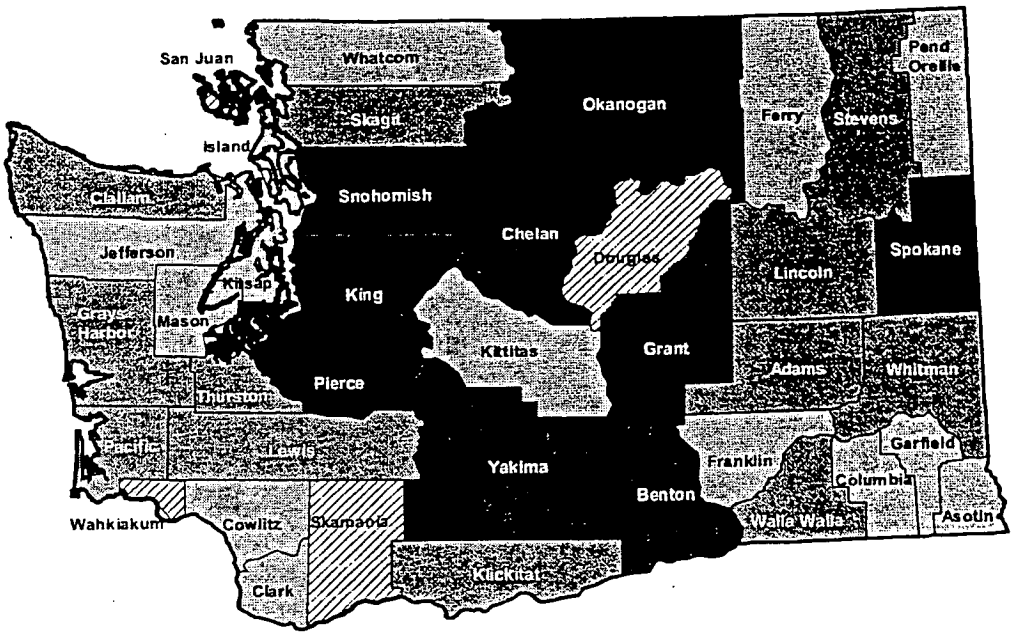


Figure 3-3
Washington State – Hospitals per County



Washington State Hospitals per County

0 | 1 | 2 | 3 to 5 | 6 to 9 | Greater than 10

Primary and Specialty Physicians in Washington

Although hospital resources in Washington are two-thirds of the national average, physician supply more closely matches national norms. There are 254 active, non-federal physicians per 100,000 population, about 6% lower than the 268 per 100,000 for the United States; about 80% of the active physicians, 212 per 100,000 are in patient care. Of these, 36 are in family or general practice, 143 are in medical and surgical specialties and the remainder are in hospital-based practices. Among the urban areas, Seattle, Olympia, Clark (Portland, Oregon), and Spokane have physician to population ratios above the state average. Yakima and Tri-Cites in the east both have physician ratios below the state average. These comparisons are shown in Table 3-3 and on the maps in Figures 3-4 to 3-6.

Table 3-3
Washington State
Physicians Per 100,000 Population
Washington Urban Areas

MSA	All Patient Care	FP/GP Practice	Specialties
Seattle-Bellevue-Everett	278	39	184
Bremerton	153	30	111
Tacoma	184	27	126
Olympia	212	37	150
Portland-Vancouver *	198	18	142
Richland-Kennewick-Pasco	133	26	97
Spokane	231	43	160
Yakima	145	32	97
Bellingham	195	44	135
Statewide	**212**	**36**	**143**

Source: American Medical Association, 2001

** Portland-Vancouver ratio calculated for the metro area that includes counties in Oregon.*

Figure 3-4
Washington State
Patient Care Physicians per Hundred Thousand

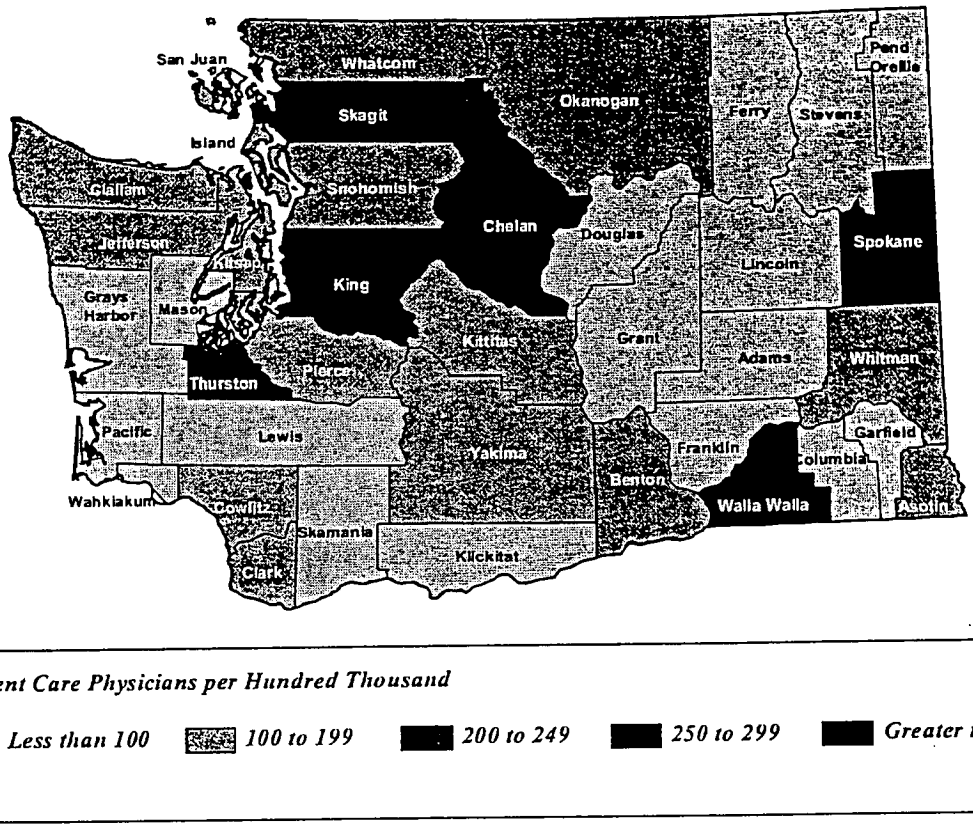


Figure 3-5
Washington State
Family Practice/General Practice – Physicians per Hundred Thousand

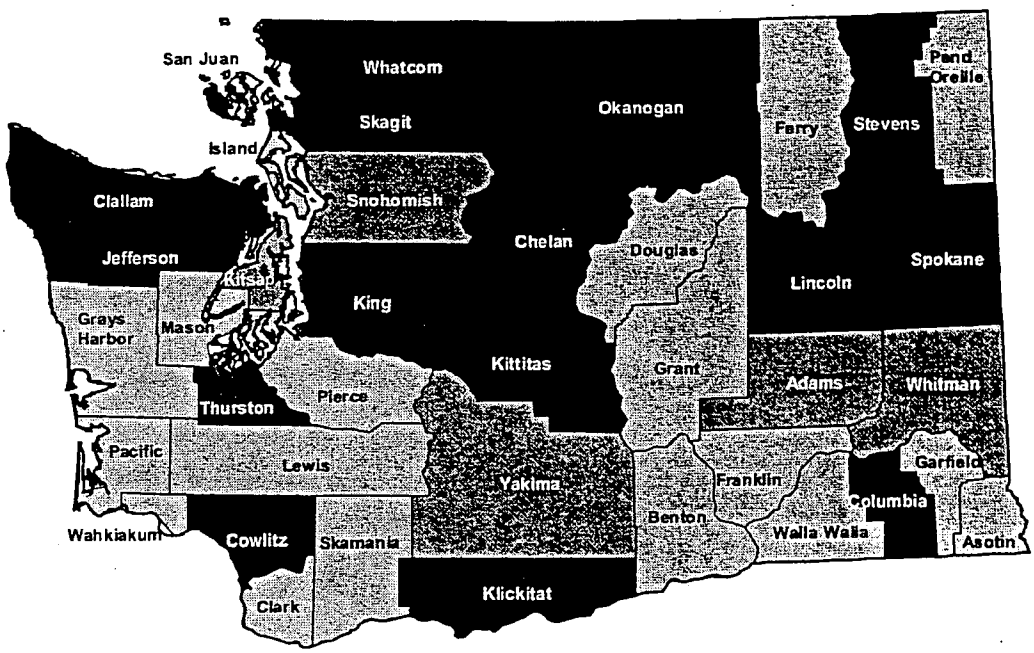
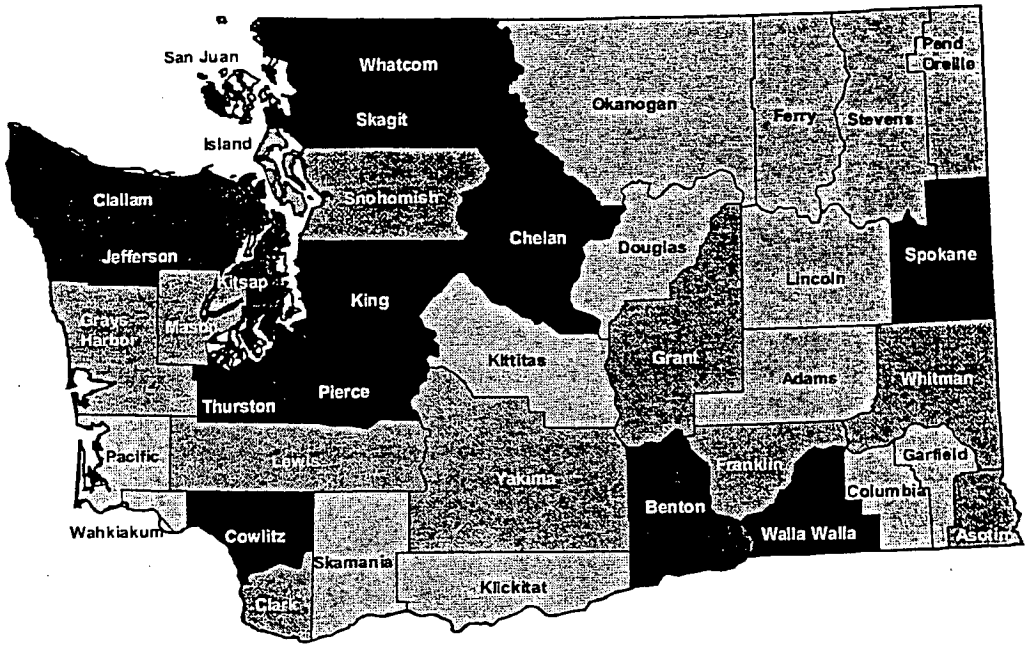


Figure 3-6
Washington State
Specialty Physicians per Hundred Thousand



4. REGULATION OF HEALTH INSURANCE PRODUCTS IN WASHINGTON

This section discusses health plan regulation in the State of Washington, with particular focus on rating and pricing methodologies and restrictions that result from those regulations.

Overview of the Process

Certain health insurance premium rates in Washington are subject to regulation. A full discussion of the regulatory process is included in the report by the Attorney General's office.[26] This section provides a general overview of the areas where premium rates are regulated and their effect on Premera's ability to change prices charged to particular groups. The Washington Office of the Insurance Commissioner (OIC) is responsible for overseeing health insurance for the state of Washington. Similar Insurance Commissioners have authority in other states in which Premera operates.

Generally speaking the regulation of health insurance pricing applies to Health Care Service Contractors (HCSC), Health Maintenance Organizations (HMO) and Disability Carriers. With regard to the Premera family of Companies, Premera Blue Cross is an HCSC, HealthPlus was an HMO and LifeWise Assurance, formerly States West Life Insurance Company, is a Disability Carrier. (The regulation follows the Company's license. HealthPlus was licensed as an HMO but now is part of Premera Blue Cross.)

Health insurance regulation varies by size of group as well as the type of insurance company. The size of group structure used by the State of Washington is consistent with the account type structure of Premera that is rolled-up into their Line of Business management and analysis.

Definition of Terms for Regulation of Pricing

To provide a frame of reference for understanding pricing constraints, the following terms are defined. These terms are relevant for both this section and Section 8 that discusses Premera's operational performance.

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[26] Leffler, Keith. "The Premera Conversion Antitrust Review, Preliminary Report." September 2003.

- Pricing: a basic term of insurance generally used to describe the process to determine a rate for health insurance coverage to be charged to an account. Since Premera has different types of accounts with different pricing parameters, there are actually a number of pricing practices and procedures.

- Account: a customer of Premera. The types of accounts are customarily reviewed in internal financial reports in a variety of ways. The types of accounts at Premera include:

  - Individual: The individual account type includes both individual commercial business and Medicare Supplement (Med Supp) healthcare business. The Med Supp business will be separated out as a product type for analytic purposes.

  - Small Group: There are different classifications of small group based on the State in which the business is sold. Generally, small group is used to refer to the most regulated category of business, where each accounts' rates do not reflect their specific experience, but rather a community rate or a modified community rate.

  - Large Group: This classification is somewhat of a misnomer. It would more properly be termed mid-size group. The level of analysis performed should not be distorted by the inclusion of several categories that cannot be divided into their sized components.

  - Government: Government includes State and Federal employee groups or programs funded by State and/or Federal Governments. The main components include the Washington Education Association, a teacher's group, the State of Washington employees group, the Federal Employees Health Benefit Program (FEHBP) and Managed Medicaid in Washington.

- Product: A general insurance term to describe the type of healthcare insurance to be provided (or sold to) an account.

  - A specific feature, such as the applicable deductible or other prevalent cost sharing requirement, can describe a product. For example, a product could be described as a low-deductible product or a high-deductible product.

  - A product can also be described by the type of network arrangement that generally governs the delivery of healthcare or by the specific type of coverage available. For example, a product could be Comprehensive Medical (no specific network) or Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO). Alternatively, a product could be a Stand Alone Dental product.

- Rating: The following of a strict formulaic approach to calculating a price for an account for a specific product. The process of rating can be used to refer to any of the following three tasks:
  - Developing a manual rate for an individual or small group account. The rates are usually posted in a rating manual or available on a rating system on the Company's central computer, or a rating diskette available to field offices or other marketing/sales force staff.
  - Developing an experience rate, which is the application of a renewal rating formula to a combination of the claims cost experience of the group and the manual rate available in the rating system.
  - The above two processes are applicable to both new business accounts and renewal business accounts. Rating, or the process of calculating "formula rates" for accounts can be a function of either the underwriting or the actuarial departments.
- Rate filing: The formal process of "telling" the insurance regulatory bodies what a Company intends to do with its rates in the upcoming periods. Rate filings are technical documents, typically accompanied by an Actuarial Certification of rates, that the theoretical structure supporting the rating process is actuarially sound. It also implies that generally accepted actuarial principles and procedures were followed in the determination of the rates to be charged. Certain accounts are charged rates fully compliant with the rates as filed. Other accounts are charged rates consistent with their own experience. For these accounts, a rating formula is filed that describes the process to be followed, rather than the specific rates to be charged.

Regulation of Individual Health Insurance in Washington

Premium rates for individual products are filed with the OIC for informational purposes only for all HCSCs, HMOs and disability carriers. The OIC cannot disapprove the rates nor impede the implementation of the filed rates. In the individual health insurance market, there is a constraint on the minimum loss ratio, currently set at 72%. If a company's reported loss ratio falls below this level, the value of the difference is paid into a designated state health insurance pool. Individual premium rates are subject to limitations in the range of rates charged. Specifically, adjusted community rating is required. The rating method used to establish premiums for health plans must reflect only actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family, size, and wellness

activities.[27] Under adjusted community rating, premiums to an individual are not experience rated. The risk pool for individual coverage includes all persons who purchase individual coverage from the carrier.

With regard to rate filings for disability carriers, forms must be filed and approved before use. For HCSCs and HMOs, forms are file-and-use, subject to disapproval.

Premera provides individual health insurance in Washington through two separate entities: Premera Blue Cross and LifeWise Health Plan of Washington. Premera quit selling new individual policies in Washington in 1998, but continued to renew members already enrolled. They reentered the market in 2001 under the separate LifeWise Health Plan of Washington and with a new individual product in Premera Blue Cross. All applicants for individual insurance, including enrollees of LifeWise Health Plan of Washington, must pass a medical underwriting test.

Premera sells Medicare Supplement Plans to individuals and to retirees in group health plans. As regards the area of health care regulation, the main focus is on Individual Medicare Supplement coverage. Regarding both rates and forms, all Medicare Supplement plans require prior approval, which means that carriers are not allowed to use the rates or forms until they are approved by OIC.

Regulation of Small Group Health Insurance

In the State of Washington, Small Group is defined as group size of 1 to 50, including self-funded employer groups, if applicable. Our understanding is that Premera does not sell self-funded coverage (or Administrative Services Contracts, ASC business) to groups of 1 to 50 employees. Small group insurance premium rates are subject to the same Adjusted Community Rating rules as those that apply to Individual coverage, with the risk pool used to establish rates restricted to the carrier's small group plans.

Rates are file-and-use, subject to OIC's disapproval for all HCSCs, HMOs and disability carriers. Premera files its small group product on a once-every-twelve-to-eighteen month cycle. The introduction of the Dimensions product portfolio required an additional filing, since the structure of the product was different from the previous small group product portfolio. Small group rates are structured as adjusted community rating. For rate adjustment purposes, the medical claim experience must be pooled for all small groups. Specifically with regard to area differentials, differences in network cost and efficiency can be factored into area differentials, but the utilization component of the small group rates must be treated similarly for the entire set of groups in the community rated pool.

[27] RCW 48.43.005(1)

Disability carrier forms must be filed and approved before use. For HCSCs and HMOs, forms are file-and-use subject to disapproval. For provider contracts and the Basic Health Plan (BHP) model plan, forms must be approved by OIC before use.

Regulation of Large Group Health Insurance

The description of Large Group covers a very broad spectrum of business in the State of Washington. Technically speaking, a Large Group is any single employer with at least 51 employees. Although this describes the group from a regulatory perspective, Premera treats this "class" of groups along a continuum of increasing coverage:

- 51-99
- 100+
- Jumbo groups

In addition to the differences by size, Premera also analyzes the business by funding arrangement. Some of the Large Groups are fully insured, some have a Minimum Premium Contract or an experience-rated contract, and some are Administrative Service Contracts (ASC). On the ASC groups, the stop-loss coverage is administered through the subsidiary LifeWise Assurance Company because HCSCs and HMOs cannot sell stop-loss policies under their license. In addition, Association coverage is regulated in this grouping. An association is treated as a large group, but typically offered to small employers that are related through professional association membership.

Rates are file-and-use subject to the OIC's disapproval for all HCSCs, HMOs and disability carriers. For HCSCs and HMOs, a large group can negotiate rates with the carrier and the OIC usually does not disapprove any negotiated rates. The administration of large group rating is better described as a rating formula. As the size of the group increases, its own experience becomes increasingly credible. The large group rating manual or rating procedures adjust the calculated rates for a variety of factors including health care trend, changes in benefit parameters and other allowed adjustments as filed with the OIC. The rates are presented to the large group account and the final rates are generally subject to the negotiation process as previously referenced.

With regard to forms, for disability carriers, forms must be filed and approved before use. For HCSCs and HMOs, forms are file-and-use subject to disapproval. For all provider contracts, forms must be approved by OIC before use.

Regulation of Government Groups

The "Government" Account Type is comprised of essentially jumbo groups (regulated in the large group arena) or government programs, such as Managed Medicaid, that are essentially self-regulated in that the premium calculated by carriers that participate are controlled by the entities administering the government program (such as the Department of Social and Health Services, in the case of Managed Medicaid, or the Federal Government in the case of the FEHBP program).

5. HEALTH PLAN COMPETITION IN THE STATE OF WASHINGTON

This section discusses health plan competition in the State of Washington, with particular focus on commercially insured business and the market position and products of the major insurers in the state. Information on the health plans was collected from publicly available data from the Washington Office of the Insurance Commissioner, reports prepared by professional associations, and interviews with health plan representatives, brokers and employers.

It is important to remember that the broader definition of the health insurance market includes the government insurance programs, most importantly Medicaid, the Child Health Insurance Program, Basic Health Plan and Medicare. The broader definition also includes people in self-insured employer plans, including many large companies and Taft-Hartley collective bargained plans. The state public employees in the Uniform Medical Plan of the Public Employees Benefits Board may be classified either under the government programs or as self-insured. As noted in the discussion of health insurance coverage in Washington state, Medicaid, CHIP, Basic Health and Medicare are estimated to cover almost 30% of the Washington State population. Self-funded firms and Taft Hartley plans are estimated to cover approximately 24% of the market. Although self-funded firms often use health insurance companies as plan administrators, that enrollment is not included in the market information reported to the Washington OIC.

In general, exclusion of the government insurance programs does not affect the insurance company market share estimates for the commercially insured. Limited information on self-insured firms has a negligible impact on the estimates of individual and small group market share because those are usually fully insured products. It can affect health plan estimates of market share for large group, and particularly the largest, or jumbo size, employers.

Overview of the Washington Health Plan Market

Annual filings with the Washington Office of the Insurance Commissioner indicate that three health plans, Premera Blue Cross, The Regence Group and its affiliates, Regence Blue Shield, Regence Care, Regence NorthWest Health, and Regence Blue Cross Blue Shield of Oregon, and Group Health Cooperative with Group Health Options, enroll three quarters of

the insured individuals in the state. As noted, approximately 89% of the Washington population has some form of private or publicly sponsored insurance.

These three insurers have historically dominated the state market, although differences emerge by line of business or group size, and by geography. National insurers, such as Aetna or CIGNA, regional plans such as HealthNet and PacifiCare, and smaller local plans may have significant market share within select markets.

Table 5-1 presents health plan enrollment for the period 1997-2002 as reported to the Washington Office of the Insurance Commissioner.[28] The reported enrollment is for insured business only; enrollment in self-insured plans, most often sponsored by large employers such as Boeing or Microsoft, is not included in the counts. During this period Premera surpassed Regence;[29] its market share rose to 28% and it is now the largest single insurer in Washington.[30] The combined business of Regence, including Regence Blue Shield, RegenceCare HMO, and the Washington based-business of Regence Blue Cross Blue Shield of Oregon follows at 27%. Group Health Cooperative and the Options Health plan rank third, with 19% of the statewide market.

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28 As summarized in Washington Hospital Association, Profile of Health Plans. Annual reports dated 1997 to 2003, for reporting years 1996 to 2002.

29 Some of the decline for Regence is attributed to the shift of Boeing from insured to a self-insured account.

30 This differs from the Premera estimates of its market share that place it second after Regence. The difference may be due to inclusion of self-insured business and Medicaid CHIP only plans in the Premera analysis. Presentation made to AM Best at March 12, 2003 Meeting. Bates Range 0032393.

Table 5-1
Washington State
Health Plan Enrollment and Market Share: 1997-2002

	Enrollment					
Plan	1997	1998	1999	2000	2001	2002
Premera	881,519	818,121	813,571	889,046	881,967	839,455
Group Health	504,772	452,173	438,554	558,957	580,872	577,702
Regence	966,325	957,730	937,593	860,970	773,271	805,775
All Health Plans	3,369,009	3,223,292	3,135,865	3,209,485	3,017,035	2,960,842

	Enrollment Market Share Percentage					
Plan	1997	1998	1999	2000	2001	2002
Premera	26.1%	25.4%	25.9%	27.7%	29.2%	28.4%
Group Health	15.0%	14.0%	14.0%	17.4%	19.3%	19.5%
Regence	28.7%	29.7%	29.9%	26.8%	25.6%	27.2%
Total of Top 3 Plans in WA	69.8%	69.1%	69.8%	71.9%	74.1%	75.1%

Source: Profile of Washington State Health Plans
Note: Plan data calculated including all operating units. The 1997 data for Premera is adjusted to include HealthPlus and the MSC enrollment that was merged in 1998.

Health Plan Market Share by Line of Business and Geography

Analysis conducted for the Washington State Task Force on Health Insurance tabulated private insurer market share by line of business as of January 2002. Results are summarized in Table 5-2. While the market share of the three largest plans was nearly 75%, it was slightly lower for the PEBB program at 71.2%, but much higher in the commercial lines of business. The three health plans enrolled 93.7% of the individual market, 91.6% of the small group market, and 88.8% of the large group market.[31]

Overall, Premera, including Premera Blue Cross and LifeWise Health Plan of Washington captured 27.4% of the private insurance market. The Premera market share is greater when examined by commercial line of business. Market share for Individual is estimated to be 47.9%; for Small Group (1-50 employees) it is 34.9%, and for insured large group, 38.5%. Share of PEBB was estimated at 11.6%.

[31] Health Insurance Market Share for Private Carriers. Washington State as of January 31, 2002. Prepared for the Washington State Health Care Task Force, "Let's Get Covered." June 2003. http://www.insurance.wa.gov/special/coverwashington/Answers/Market_share_analysis.pdf

Table 5-2
Washington State
Health Insurance Market Share
Enrollment in Top Three Health Plans by Line of Business, January 2002

Line of Business	Total % of Market	Premera	Regence	Group Health	Sum of Top Three	Premera Market Share	Top 3 Market Share
Individual	4.76%	2.28%	1.53%	0.65%	4.46%	47.90%	93.72%
Small group	11.84%	4.13%	6.01%	0.70%	10.85%	34.88%	91.65%
Large group	40.33%	15.51%	10.56%	9.75%	35.82%	38.46%	88.82%
Basic health plan	4.78%	0.63%	0.78%	0.65%	2.06%	13.18%	43.04%
Public employee	5.79%	0.67%	0.62%	2.84%	4.12%	11.57%	71.15%
Other plans	32.49%	4.13%	5.03%	8.34%	17.50%	12.71%	53.85%
Total market share	100.00%	27.35%	24.53%	22.93%	74.80%	27.35%	74.80%

Source: Health Insurance Market in Washington State: Health Insurance Market Share for Private Carriers. Prepared by WA State Office of the Insurance Commissioner.

http://www.insurance.wa.gov/special/covered washington/Answers/Market_share_analysis.pdf

The OIC requires health plans to submit Form B enrollment reports for insured business. It reports enrollment by county for each product by line of business (individual, small group, and large group). Aggregating the insurer reports permits estimates of the number insured by county and health plan market share by line of business within county. Because the reported figures are insured lives only, it does not include self-insured members and therefore is a less accurate measure for the large group business, where national insurers also compete. The 2002 Form B submissions were collected and used to calculate more detailed market share statistics by county and line of business. When these figures are reviewed, a more detailed picture of market share emerges for each of the three major plans.

Premera, Regence and Group Health compete most directly in King County and its surrounding counties. In the counties that comprise the Seattle Metropolitan Statistical Area, Regence has a 37% market share, Premera is second with 31% and Group Health is third with 22%. The market share distribution is similar for all western counties combined.

Market share rankings shift substantially in the eastern Washington counties. Premera, in large part because of the 1998 merger with Medical Service Corporation, has a dominant market position, with an overall 70% market share. Group Health, which operates primarily in the Spokane, Walla Walla and Yakima areas, reports 17% market share. Regence and its

affiliates have an estimated market share of 12%, primarily through its presence in Yakima and Walla Walla.

The market share estimates also vary by line of business. The Form B requires reporting insured business enrollment for Individual (self-purchase), Small Group (1-50 employees), and for Large Group (Over 51 employees). As local plans, Premera, Regence and Group Health, maintain their market share dominance in the individual and small group markets. However, there is more competition in the large group market, particularly groups with more than 100 employees and jumbo and national accounts. The competition is in the form of additional plans, such as Aetna and PacifiCare, and employer self-insurance (Administrative Services Contracts or ASC). Tables 5-3 and 5-4 present the market share estimates for the insured lives by geography for 2001.[32]

Table 5-3
Washington State
Insured Lives 2001
By Geographic Region – All Lines of Business

	Western WA	Eastern WA
Group Health	21.0%	16.7%
Premera	29.7%	69.9%
Regence	37.7%	11.8%
Total of Top 3 Health Plans	**88.4%**	**98.4%**
Total Members Top 3	1,281,001	376,190
Total Members reported	1,448,552	382,294
Note: Out of State not included		

[32] A review of the 2003 Form B filings with 2002 enrollment data indicated that there were changes in reporting instructions which distort how line of business categories are reported for selected carriers. In general, unless there is a major change in the market, such as merger or entry and exit of health plans, year-to-year changes are relatively small.

Table 5-4 King and Spokane County Insured Lives 2001 All Lines of Business		
	King	**Spokane**
Group Health	22.0%	22.5%
Premera	30.7%	67.1%
Regence	36.9%	8.1%
Total of Top 3 Health Plans	**89.6%**	**97.7%**
Total Members Top 3	556,259	139,357
Total Members reported	620,637	142,654

Tables 5-5 and 5-6 present similar market share information by line of business and geography.

Table 5-5 Washington State Market Share by Geographic Region By Line of Business, 2001						
	Individual		**Small**		**Large**	
	Western WA	**Eastern WA**	**Western WA**	**Eastern WA**	**Western WA**	**Eastern WA**
Group Health	15.0%	5.5%	7.2%	1.8%	24.1%	21.9%
Premera	36.5%	81.4%	27.6%	87.6%	29.5%	63.8%
Regence	45.0%	13.0%	53.3%	10.5%	34.1%	12.2%
Total of Top 3 Health Plans	**96.5%**	**99.9%**	**88.1%**	**99.8%**	**87.7%**	**97.9%**
Total Members Top 3	107,687	17,444	182,353	84,947	990,961	273,799
Total Members reported	111,574	17,455	207,011	85,078	1,129,968	279,761
Note: Out of State not included						

Table 5-6 King and Spokane County Market Share by Line of Business, 2001						
	Individual		Small		Large	
	King	Spokane	King	Spokane	King	Spokane
Group Health	17.3%	14.5%	6.0%	3.1%	25.6%	28.5%
Premera	40.8%	84.7%	31.5%	89.2%	29.4%	59.9%
Regence	41.1%	0.7%	55.5%	7.5%	32.9%	8.6%
Total of Top 3 Health Plans	**99.2%**	**100.0%**	**93.0%**	**99.8%**	**87.9%**	**97.0%**
Total Members Top 3	53,821	4,748	83,654	31,114	418,784	103,495
Total Members reported	54,235	4,749	89,942	31,181	476,461	106,724

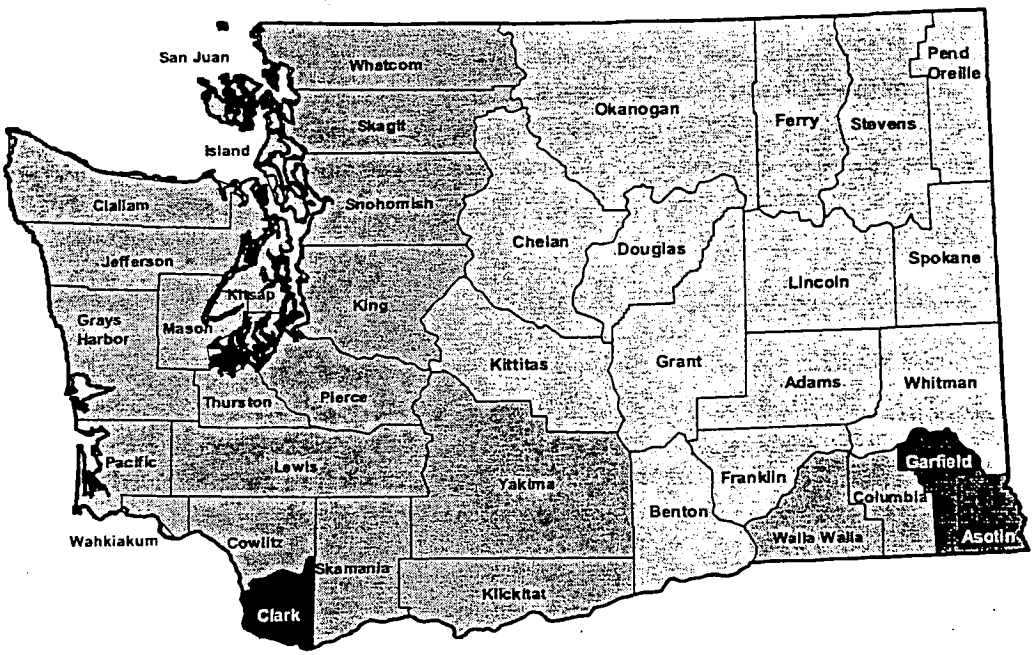
Blue Cross and Blue Shield Service Mark in Washington

Historically, the Blue Cross service mark is associated with health plans developed by hospital associations and the Blue Shield mark is associated with medical service bureau plans formed by groups of physicians. As health insurance programs developed, many, but not all, Blue Cross and Blue Shield organizations merged within geographic areas.

Four plans hold the Blue Cross or the Blue Shield service mark in Washington. Premera Blue Cross has the license for the Blue Cross service mark statewide, except for Clark County. Both the Cross and Shield service marks for Clark County belong to Regence Blue Cross Blue Shield of Oregon. Regence Blue Shield of Washington holds the Shield service mark for most counties in western Washington and competes directly with Premera Blue Cross in the overlapping service area. It also has the mark for four eastern counties, Klickitat, Yakima, Columbia and Walla Walla. Through the merger of Blue Cross of Washington and Alaska and the Medical Services Corporation of Eastern Washington, a Blue Shield plan, Premera Blue Cross holds the Shield service mark for 14 of the counties in the eastern side of the state. Regence Blue Shield of Idaho has the mark for the remaining two counties in southeastern Washington, Garfield and Asotin.

The Blue Cross and Blue Shield service areas for each of the plans are shown in the map in Figure 5-1.

Figure 5-1
Blue Cross and Blue Shield Service Marks in Washington



Any Blue Cross or Blue Shield plan wishing to offer health insurance products outside of its licensed Blue Cross or Blue Shield service area must market those products under other brand names based on rules of the national BCBS Association. For Premera Blue Cross, the non-Blues products are marketed under the LifeWise name. For Regence Blue Shield of Washington, they are marketed through Regence Northwest Health under the name Asuris.

Competitor Health Plan Products and Market Strategy

The three leading health plans in the state offer a different mix of products to the market. Discussions with brokers, employers and health plan representatives suggest that health plan

benefit design reflects a "moderate" level of managed care incentives in products purchased by employers. In general, the major products for both Premera and Regence are Preferred Provider Organization (PPO) with comprehensive contracted networks. A common level of deductible is $250 and the co-payment for office visits average $10 or $15 dollars. Tiered outpatient pharmacy benefits have recently been introduced.

Although Regence and Premera each have a health maintenance organization (HMO) product, HMO product design is more closely associated with Group Health and its staff model organization. HMO products have been decreasing as a proportion of the total insured market. Point of Service (POS) benefit design is available and is a relatively small, but increasing, portion of the market.

Regence Group and Regence Blue Shield of Washington

Regence Blue Shield of Washington is one plan in the non-profit Regence Group of affiliated Blue Cross and Blue Shield plans that serve Oregon, Washington, Idaho, and Utah. With an overall market share of approximately 25% of the insured business in Washington, Regence Blue Shield has significant market share in both Individual and Small Group markets. Recent estimates are that the Regence group enrolls almost a third of the individuals with private insurance and over half of the employees in small groups.

Regence Blue Shield has PPO, POS, Traditional and HMO products, as well as dental products. It sells Medicare supplemental coverage and participates in both Healthy Options and the Washington Basic Health Plan.

Individual products are Selections, a POS product, and Preferred Plan PPO, with a choice of comprehensive or catastrophic coverage and various levels of deductible. Regence Blue Shield, like Premera, had stopped enrolling new members in the individual products, but re-entered the market in 2000 after the passage of the insurance reform legislation.

Group products are Selections POS, the Preferred Plan PPO, traditional plans, and RegenceCare, an HMO. Based on reports to the Washington OIC, the POS and PPO products are equally popular among small and large employers and the PPO product recently expanded into Yakima. The company is withdrawing its HMO product from the group market. Beginning May, 2003, Regence stopped providing quotes on new RegenceCare business. And it has announced that as of November 2003, it will no longer renew coverage of existing groups.

The company successfully introduced a new small group PPO product in 2002, FourFront that is priced 10% to 15% below other products that have been offered to that market. The product design includes coverage of the first four office and hospital outpatient visits and

$500 of outpatient diagnostic laboratory and radiology services per person that is subject to co-payments, but not to a deductible. The fifth and subsequent visits or lab and radiology services in excess of $500 per person are subject to an annual deductible. All other services are covered at a percentage of the allowable amount, with percentages varied by whether the provider is part of the Regence preferred provider network. The product has been marketed only in Western Washington and sales of the product approached 20,000 lives in the first year.[33]

Regence is expanding into the eastern Washington market through the non-Blue Asuris Northwest Health brand and reports enrollment approached 30,000 in 2002. This includes commercial insurance, Medicare supplemental, and participation in the public programs for Healthy Options and the Basic Health Plan.[34]

Group Health Cooperative of Puget Sound

Group Health Cooperative of Puget Sound is one of the nation's first integrated delivery systems, the precursor of today's health maintenance organizations. It was formed in 1947 by a coalition of consumers, business and labor leaders, and physicians, and serves over 600,000 members in Washington and Idaho.

Group Health does not have statewide operations; it has networks in 17 counties, parts of 3 additional counties and two counties in Idaho. The service area encompasses the extended western metropolitan area, the central region of Yakima, Walla Walla, and Tri-Cities, and the eastern region of Spokane.

The health plan serves the commercial sector with HMO and POS products, and participates in Medicare+Choice managed care, Healthy Options and the Washington Basic Health Plan.

The Group Health Individual plans offer a comprehensive and catastrophic benefit design that is similar to the Premera and Regence benefit design rather than first dollar coverage. Services are subject to annual deductibles and percentage co-payments.

Small and large group plans include the Group Health HMO plan, Options, a POS design and Alliant Plus, a POS plan that uses Group Health and contracted medical specialty groups as primary care providers. The Group Health HMO plans include first dollar coverage with no deductible and dollar limits on co-payments as well as plans with deductibles and percentage

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[33] Regence Group. Annual Report, 2002. Marketing was limited to Western Washington because provider contracts in Eastern Washington would not deliver the desired premium differential. Personal Communication.

[34] Ibid.

co-payments. The Options POS program uses Group Health providers at Group Health owned clinics for in-network services and contracts with First Choice Health Network for out-of network providers. The Alliant Plan expands the Group Health provider network by contracting with physicians from Virginia Mason and the Everett Clinic, both in the Seattle area, for an expanded HMO network or as the in-network providers of the Alliant Plus POS plan.

Other Insurers

Aetna and First Choice Health are significant competitors in the large group and self-insured markets. Until this year, Aetna held the Microsoft account that Premera now administers. Plan representatives estimated that the company may have as much as 50% of the national accounts in the Spokane area, primarily as "branch" business, the local offices of national accounts that have headquarters in other locations. It does not participate in the individual and regulated small group markets. Aetna stated that it hopes to grow by building on its provider networks in Puget Sound, Spokane County and Wenatchee and evaluating opportunities in other areas such as Yakima and the TriCities.

First Choice Health Network is Washington's oldest and largest Preferred Provider Organization, with provider networks in Washington, Alaska, Idaho and Montana. It was established in 1984 with shareholder hospital and physician ownership and as of June 2002 served 1.2 million people through self-insured accounts, union trusts, and as a leased network for other insurers and national networks.

First Choice Health Plan is licensed as a Health Care Service Contractor and serves members in King, Lewis, Mason, Pierce, Snohomish, Thurston and Spokane counties with an insured product. Major clients include Costco and Boeing. The insured plan was established in 1996 and the highest level of enrollment was approximately 70,000. First Choice Health plan has stopped issuing proposals and is exiting that business by not renewing contracts. It expects to transition all members as of the end of the year. As of January 2003, First Choice Health enrolled approximately 25,000 members; with one half of this membership in Boeing.

6. PROVIDER CONTRACTING AND PAYMENT METHODS

This section presents information on the contracted hospital and provider networks and payment methodologies for Premera products, and comments on how they compare to the networks and payment of other health plans in the market. These findings are based on information provided by Premera as part of the transaction proceedings, interviews with Premera provider contracting and provider relations staff, and interviews with competitor health plan representatives and hospital and physician groups in the state.

Provider Networks

Premera Blue Cross is acknowledged to have the broadest contracted network in the state for PPO products, with over 10,000 physicians, 6,000 clinical providers, and nearly all of the hospitals in the state. Regence Blue Shield has a comparable, though slightly smaller, contracted network in the overlapping service areas in the Western part of the state and has built a network similar to Premera over the past years for the Regence non-Blue Asuris product in the eastern counties. First Choice Health Network, a provider owned organization, includes a significant proportion of the major hospital systems and physician groups among its shareholders, and has established contracts with other hospitals and providers to assemble a network that is considered competitive with both Premera and Regence Blue Shield. The First Choice Health Network is the leased network of a number of the national insurers with accounts in the state and is also leased by Group Health Cooperative as the out-of-network alternative for its Point of Service Options product.

In contrast, Group Health Cooperative has a smaller network that reflects both the delivery model and the fact that it does not operate statewide. In its Seattle/Western region, the health plan relies on its core of staff physicians and owns its hospitals. In the Spokane area, Group Health has staff model primary care clinics, but contracts with local provider groups, including the Everett clinic, for additional capacity and specialty care. It does not own a hospital and therefore contracts with some of the community facilities. Statewide, there are more than 1,000 physicians in the affiliated medical group, Group Health Permanente, and there are contracts with another 6,500 community based physician and other clinicians in their service area.

Washington employers and members have desired a broad professional provider network. The size of the Premera network has been credited as part of the reason that Microsoft recently switched its employee plan from Aetna.[35] Numbers provided by the company estimate that the PPO provider network represents approximately 95% of the potential network.[36] The smallest provider network, for the HealthPlus HMO product, still has an estimated 74% of potential providers and the Foundation network, the core network for the new Dimensions product, has an additional 700 providers, or an estimated 76% of potential providers. The approximate number of contracting providers for other Premera products and networks is shown in Table 6-1.

Table 6-1
Premera Blue Cross
Contracted Provider Networks

Network	Number	% of Total
PBC Traditional/Participating	15,500	92%
PBC Preferred PPO	16,000	95%
HealthPlus HMO	12,600	75%
Dimensions Foundation	13,300	79%
Dimensions Access	13,400	79%
Dimensions Heritage	16,100	95%
Total Unique Providers	16,900	100%

Source: Premera Provider Database, November 2002
Bates Range 0029258

Provider Payment

The predominant payment methodology among health plans in Washington State is fee-for service; Premera phased out capitation contract for its HMO product and most of the other health plans with HMO products have followed a similar course.[37] The company now uses the same payment methodology across all products.

The common method of inpatient hospital payment is either a case-rate DRG-type used by Premera or per diems (per day) that may vary by level of service, such as acute medical-

[35] Microsoft had offered an Aetna product since 1999.

[36] Premera Network participation as of November 2002. Bates range 0029258.

[37] Physicians in the Group Health affiliated Permanente group are usually salaried with incentive payments while contracted physicians are paid a mixture of capitation and fee for service. The PacifiCare Medicare+Choice contract pays capitation for professional services using a percent of premium formula.

surgical, Obstetrics/nursery, cardiac and intensive care that is used by Regence. Rural hospitals and sole community provider hospitals are usually paid on a negotiated percentage of charges. Hospital outpatient may be a mixture of ambulatory surgery case rates based upon ambulatory payment groups (APGs) and a percent of charges for other services.

[PROPRIETARY MATERIAL REDACTED]

Physician payment is based upon a maximum allowable fee schedule. Both Premera and Regence fee schedules are linked to the Medicare physician Resource Based Relative Value Scale (RBRVS) methodology, but each has adopted variations in how it is applied.[38] Services that do not have a Medicare RBRVS unit value, including clinical laboratory, durable medical equipment, and services paid relative to average wholesale pricing (immunizations and injectable drugs), are paid at a percentage of the Medicare rate.

Interviews with physician groups and health plan representatives confirm that fee schedules for Premera and Regence are quite similar in Western Washington, with some groups claiming higher payment from Premera and others saying that Regence pays at a higher level. Overall, the estimated differences were 5%. The opinion regarding which company is the higher payer appears related to the mix of services that the medical group or physician provides and the comparative payment levels for those services.

Payment differences in Eastern Washington are reported to be larger. Health plan and medical group representatives stated that Premera reimbursement rates are lower than those of the other health plans. Physicians reported resisting these lower payment levels in Eastern Washington for several reasons. First, Medicare and Medicaid are a relatively high proportion of the payer mix and have low reimbursement rates. Providers often attempt to offset low payments for public patients with higher commercial payment levels. Second, Spokane and the surrounding counties have provider groups with dominant market share. As a result, they are less willing to give discounts to the health plans that do not have significant member volume.

At one time, Premera maintained different payment and fee schedules for different products. There were different payment levels for HealthPlus HMO (particularly when it was a

[38] It is possible to have variation in fee schedules that are based on the Medicare RBRVS. Differences can include the year of the RBRVS schedule and the use of national or geographically adjusted factors. Both will affect the unit value for a given procedure. The other major component is the conversion factor, the dollar amount that is multiplied by the RBRVS units to determine the payment amount.

capitated product)[39], the PPO fee schedules and the Traditional FFS "participating" provider fee schedule based on a "usual and customary" methodology. In the past few years, Premera has moved from multiple fee schedules to a single maximum allowable schedule for all products for most physician contracts within a geographic area.

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PROPRIETARY MATERIAL REDACTED

[39] Washington law permitted physician groups to assume "full-risk" capitation. This is capitation payment for all (or the majority) of services covered under the benefit package. In general, this would include all primary care, specially care, ancillary services, and hospital care.

[40] Bates range 0019023.

[41] For the year started September 1, 2000, the move from the 1998 to the 2000 RBRVS incorporated the Medicare recalibration that substantially reduced reimbursement for some specialty codes. Premera limited the amount of decrease for any CPT to (-7%). PBC Fee Schedule Update to Providers Bates Range 0023005-0023017.

[42] Medicare divides Washington into two regions, King County and all other. King County is weighted above the national average and the rest of the state is below the national average.

[43] Results of Dyckman & Associates study for the Medicare Payment Advisory Commission (MedPAC) as reported by Premera. This was based on the fee schedule that went into effect on September 2002.

[44] Bates range 0035574-0035575.

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Over the past few years, Premera has also incorporated quality and other incentive targets within contracts with some physician groups. These may focus on outpatient drug prescribing patterns, referral patterns or cost of care and use of resources used to treat selected conditions.

Using claims payment data developed for federal 1099 filings, the three largest hospital providers are, Swedish Health Services in Seattle, Sacred Heart Medical Center in Spokane , followed by the University of Washington in Seattle. Other hospitals among the top ten providers include Virginia Mason, Empire Health Services, Harborview Medical Center and Children's Hospital. The same data for 2000 to 2001 indicates that the major physician provider groups in the Premera network include Wenatchee Valley Clinic, Rockwood Clinic (Spokane), Everett Clinic (Seattle), Association of University Physicians (Seattle), and Cancer Care Northwest.[45]

The effect of the different hospital and provider contracting arrangements and the levels of provider payment are partially reflected in the area factors included in Premera small group rate filings submitted to the Office of the Insurance Commissioner. These factors are developed based on network efficiencies that reflect the cost of providing care in that area. Because the regulated small group products are community rated, these factors are not intended to capture differences in health risk and utilization. Area factors consistently show Seattle and the surrounding metropolitan area above the state average and the Spokane area factors below the state average.

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[45] Bates Range 0018641-0018644.

[46] Bates Range 0024815.

PROPRIETARY MATERIAL REDACTED

Dimensions Product Contracting and Payment

As part of the development of the Premera Dimensions product, the company conducted a comparative analysis of hospital and physician providers to measure cost-effectiveness and efficiency. The hospital analysis developed case-mix measures that were combined with information on hospital costs from the Premera allowed payment amounts and the level of contracted discounts to determine a relative rank within the state and in geographic markets. The physician group analysis calculated a cost per unit Episode Treatment Group score based upon the Premera fee schedule conversion factor and the RBRVS units to determine physician rankings within the state and in geographic markets. [47]

These rankings were used to develop preliminary targets for the size and composition of the four tiers of networks within the Dimensions product. Foundation, the core network, includes physicians signing the standard fee schedule contract. It also includes larger physician groups with fee schedules above the standard if it has a low episode treatment score, reflecting more efficient and cost-effective providers. The Access network includes the Foundation providers and those providers already in the Premera PPO network who signed a Dimensions contract addendum. Financial performance standards are not a requirement for participation in the Access network. The Heritage network, the largest contracted network, most nearly mirrors the current Prudent Buyer PPO product network.

The current Dimensions network configuration indicates that the majority of physicians are participating in the Dimensions product. Overall, 96% of all contracted physicians participate in a Dimensions network. In the Western part of the state, somewhat more than half are part of the Foundation network and over 70% are part of the Access network. Over 20% contract through the Heritage network only. In the eastern part of the state, approximately 85% participate in the Foundation network. The Access network is only marginally larger, and somewhat more than 95% contract in Heritage.

The hospital contracts for the Dimensions products also include the majority of hospitals that are contracted under the Premera PPO product network. The Dimensions Heritage network, designed to mirror the PPO product, has the same number of contracted Washington hospitals and another three hospitals in Idaho. The Foundation network has contracts with 8 fewer hospitals. It is interesting that both the Dimensions Foundation and Access networks contract with fewer hospitals than are in the HealthPlus HMO network.

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[47] Unit cost index is calculated as allowed dollars per relative value unit. The relative value units are standards developed by Milliman USA that are based on APRDRG category and length of stay.

[PROPRIETARY MATERIAL REDACTED]

Table 6-2 Premera Blue Cross Number of Hospitals by Network	
	Number of Hospitals
Dimensions products	
Access	86
Foundation	85
Heritage	93
Other PBC products	
HealthPlus	92
Premera Blue Cross Preferred	93
Premera Blue Cross Participating	97

[PROPRIETARY MATERIAL REDACTED

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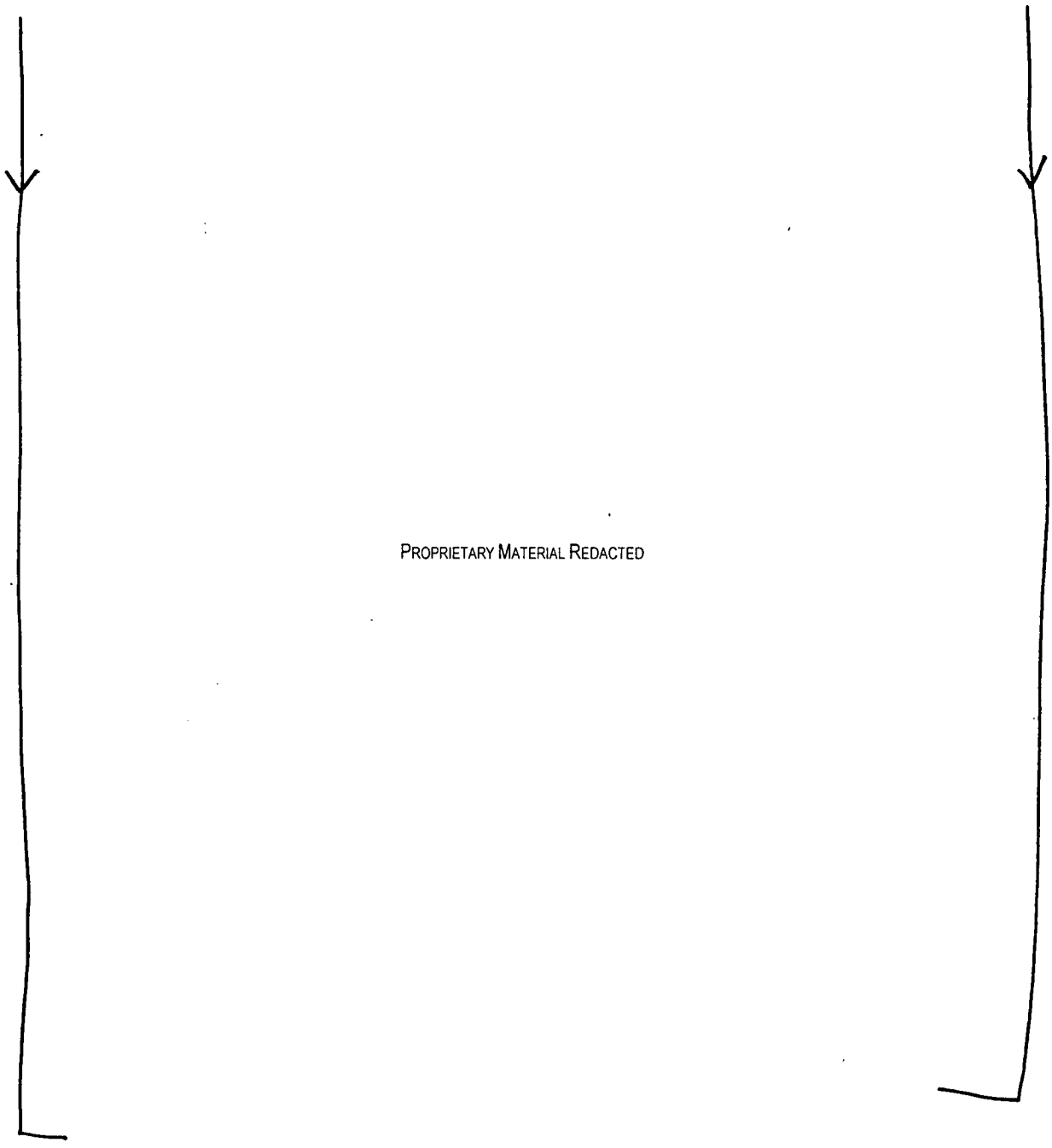
[48] Small group rate filings include the six rating areas. Current Large Group filing is based on East and West, but will be changed to the six rating areas in a future filing.

[49] Memo from Audrey Halvorson, Chief Actuary in re Dimension Rate Filing Summary for Washington. September 24, 2002.



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7. PREMERA BLUE CROSS OPERATIONS IN WASHINGTON BY LINE OF BUSINESS

This section discusses health plan operations of Premera Blue Cross in the State of Washington, with particular focus on the financial performance of the commercial lines of health business and differences that may be evident by product or by geographic area. It discusses general performance in the State of Alaska and the performance of the subsidiaries only as they relate to Premera's overall performance. Historical information is taken from submissions to the Office of the Insurance Commission, audited financial statements and documents provided by the company.

The terms defined in the Section 4 are used here; additional terms are also defined to assist in understanding operational performance and general insurance company pricing strategies that are common in health insurance markets.

Definition of Terms

The process of pricing at Premera Blue Cross involves a number of tasks and different functional departments. To properly describe all components of pricing, it is first necessary to define the terms being used to assist in clarifying the issues. In addition to those defined in the prior section, the following terms are relevant:

- Risk selection: The process of matching the Company's guidelines for selecting and rating accounts. Certain accounts will have a risk profile unacceptable to the Company. For most accounts, the actuarial department determines rating factors to be used to match the selected risk with an appropriate rate.

- Underwriting: This is a term broadly utilized to describe the processes of risk selection, rating and pricing for an account. The risk selection guidelines are usually referred to as underwriting guidelines. There is usually an underwriting manual or an underwriting document termed policy and procedures that assists the individual underwriters with the entire process.

- Pricing adjustments: Before a "rate" is communicated to an account, there can be adjustments to the rating process. Depending upon the State regulation, no pricing adjustments beyond the filed rates may be allowed. On accounts in the Large Group

and Government Group, pricing adjustments may be allowed and would be developed as a result of case specific facts and circumstances. (Premera uses a process termed the Business Decision Reports "BDR" to determine whether adjustments to standard rates are appropriate. For very large accounts, a separate detailed analysis may be used.)

- Operating Margin: When all claims, sales and administrative expenses and premium taxes are subtracted from premium revenue, the remainder is operating income. The gain or loss in operating income, divided by revenue, and expressed as a percentage, is the operating margin. This may also be referred to as contribution margin.

- Target Operating Margin: The level of desired profitability of a line of business is the target operating margin. The target operating margin will differ by line of business and is usually built into the rating formulas used to establish the premium for an account. A target operating margin needs to be achieved to add to reserves and accumulated risk-based capital, in order for the Company to remain viable.

- Line-of-Business: A specific aggregation of accounts with similar characteristics. The Line-of-Business (LOB) is a primary management category used by most companies to analyze, monitor and manage their business operations.

- Annual Budget: The Premera budget process is similar to that used for many companies. The historical information by LOB is analyzed, additional facts and circumstances are documented, and a projection into the future is made. All Companies have an annual budget. Some companies project further into the future to develop a longer-range plan.

- Actual Operating Margin: The achieved level of gain or loss of a line of business, expressed as a percentage of revenue, is the actual operating margin. The finance department monitors the results of the operation of the LOBs. Periodic reports are prepared to analyze results over time.

- Comparison of Actual to Expected: One function of the periodic management reports (e.g., Premera's Beige Books) is to compare actual performance to expectations. The expectations used for comparison might be the annual budget, last year's operations, or the theoretical target for the LOB, as determined either by the rate filings or the marketplace. For a not-for-profit company, the theoretical target is more likely determined by general marketplace pressures. For a for-profit company, other investment alternatives, including other for-profit benchmarks, will most likely determine the targets.

Premera Performance by Line of Business: Actual 1997 - 2002

We analyzed Premera's product pricing to allow us to assess their performance against pricing targets. Technically, any missed pricing "target" can be termed under-performing. However, the goal of financial analysis and planning, underwriting, actuarial, and senior management is to establish a process of reviewing emerging experience. Through this process, pockets of under-performing lines of business can be analyzed and corrective actions plans can be developed.

The analysis examined pricing in two ways:

- Account type, defined as Individual, Small Group, Large Group and Government; and
- Geography, subset by Western Washington, Eastern Washington, Alaska and Oregon.

Premera has different market positions in each of the four geographic regions.

Determination of whether a plan is under-performing also depends on the broader health insurance market. At times, the market will cycle from a profit position to a loss position. Consequently, for short periods of time, the entire health care market in a defined region could lose money. This circumstance alone does not prove under-performance against the target. Similarly, moving from a profit to a loss position does not prove under-performance.

This analysis uses the following definition for under-performing: Financial results over several years that are consistently lower than generally acknowledged performance target(s). Table 7-1 shows Premera's corporate performance as measured by Operating Income percentage (also called operating margin) from 1997 to 2002. The table shows growth in premium revenue and a return to profitability over the six-year experience horizon.

Table 7-1 Premera Blue Cross Operating Income by Year						
Calendar Year	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Premium revenue ($ in millions)*	$ 1,366	$ 1,476	$ 1,645	$ 1,960	$ 2,375	$ 2,557
Operating income (loss) as a % of premium revenue	(4.0)%	(1.2)%	1.0%	1.0%	1.2%	1.6%

**Reports Results of Premera Consolidated Operations. Excludes Large Group ASC as recorded in WA 26. When comparing historical values to projections, the values as presented would be reduced for consistent losses on Large Group ASC business throughout the period analyzed. Refer to Table 7-10.*

Source: Premera Line-of-Business reports.

Pricing by Account Type

Health insurance pricing in Washington is a function of several factors, including group size, geography, and a plan's competitive position. Premera has shown varying levels of operating margin for different account types and lines of business, with variation by year.

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[50] Premera Blue Cross Individual Rate Filing, Effective June 1, 2002.

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Small Group

The term small group is used to refer to the accounts where the rates are regulated and reviewed and each group's experience does not directly enter into the rating calculation for that group. In Washington the regulated small account size is 1-50; in Alaska the account size is 2-99; and in Oregon the account size is 2-25.

Table 7-5 presents Small Group account profitability for all of Premera and Table 7-6 presents results by geographic region.

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The target operating margin on small group accounts is 4%.[51] Taken in total, Premera has generally achieved target margins from 1999 to 2002.

[51] Premera Blue Cross Small Group Medical and Dental Dimension Rate Filing, Proposed Effective Date September 1, 2002.

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Large Group

Table 7-8 presents Large Group results. The Large Group account experience has fluctuated generally between a 3% loss and 2% gain over the six-year period analyzed. The target profits for the Large Group Account type are 2%.[52] Generally, for-profit companies fluctuate between 0% and 4%. for this line of business.

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Among the Large Group account type, there are two lines of business that do not "neatly" fit into the matrix constructed for analysis – HealthPlus Commercial and Associations. The HealthPlus HMO had been a stand-alone entity until combined into Premera Blue Cross in 2000. The Association groups are an amalgam of groups that are potentially of all account types. For this reason, the two lines of business are reported separately in subsequent tables.

52 PBC Large Group Rate Filing, Effective Date July 1, 2002. factors applied to mix of business.

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Government Accounts

The Government Line of Business termed for this pricing analysis is comprised of the following sub-lines of business:

- An insured accounts of State or Federal Government Employees, for example, WEA (State of Washington Teachers), PEBB (Public Employees of the State of Washington) or Federal Employees Program (FEP, also known as the Federal Employees Health Benefit Program or FEHBP) ;
- A program funded or managed in accordance with Federal Government guidelines, for example, Medicare or Medicare+Choice;

[53] Analysis of rate filings, discussions with Premera management, recognition of actual experience over time and consideration of stop-loss experience.

- An insured program managed in accordance with State and Federal Government guidelines, for example, Medicaid managed care programs, known in Washington as Healthy Options; and
- The Washington Basic Health Plan, a subsidized insurance program for low income populations.

The operating results for this line of business are summarized in Table 7-11.

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Healthy Options Premium revenue ($ in millions)	$91	$92	$66	$52	$68	$75

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Basic Health Plan Premium revenue ($ in millions)	$70	$47	$59	$55	$41	$44

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[54] Conversations with Premera management and staff.

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Performance by Line of Business: Projections 2003 - 2007

Corporate Projections

The application for conversion requires the company to prepare a management projection of future results.[55] The projections for the period 2003 to 2007 represents management's current plan for performance over the next five years. Table 7-12 presents operating margins, and therefore reflects pricing for the various lines of business.[56] Results are combined for the Washington and Alaska operations. The Other category includes non-health insurance subsidiaries as well as the planned expansion into Arizona.

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[55] Form A, Exhibit E-7. Overview of New Premera Operations and Strategy and Rationale for Conversion. Section IV is Premera Combined Financial Projections and Assumptions. This section and the Actuarial Opinion are redacted from the public posting of the Form A application.

[56] The five-year projection did not consistently allocate Sales, General & Administrative (SG&A) expenses according to formulas suggested as a result of the consultant's analyses over the course of the engagement. The table presents operating margins for the base case as originally prepared by Premera management.

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Washington State Projections

The operating margin projections for business in the State of Washington is presented in Table 7-13.

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Table 7-14 presents the projections for the western and eastern Washington business units.

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Assumptions Underlying Baseline Projections

The baseline projection model developed by Premera management relies on a set of assumptions regarding changes in health care costs, in expenses such as premium tax, commissions and general administration, and membership increases or decreases. Projections must also factor in changes in the business, such as the development of new products, entry or withdrawal from select markets, and the impact of changes in the mix of business. A bottom-up projection model, such as the one developed by Premera, evaluates each factor for the line of business and aggregates projections to market business units and consolidates the estimated corporate results. Because there is less certainty about the factors as the projection period increases, a projection cannot be held to the standard of a budget. However, it should reflect management's best judgment of what can be achieved within the time period and is subject to a "reasonableness" analysis.

Based on operating margin analysis, it appears that the management projections show continued improvement in operating margin, but may not achieve market-based target levels or levels achieved by other for profit health insurers in the market.[57]

[57] An update of Premera's financial projections was presented to Premera's Board on October 6th [ ] That

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Consolidated Corporate Assumptions

The major assumptions in the consolidated corporate baseline model, which includes existing operations in Washington, Alaska and Oregon, a new market expansion into Arizona and the results of subsidiary company operations, are summarized in Table 7-15. They are presented as the change between actual results for 2002 and the projected results for 2007 with a five-year calculated compound annual growth rate.

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presentation showed substantial changes in values that require additional time for analysis. Because there was insufficient time to assess the revised projections and to discuss the basis and reasonableness of the changes in the model with Premera management, we have not incorporated those values into our analysis. Further, Premera has indicated that the updated planning model is not to be considered a revision to the application for conversion.

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Washington Enrollment and Product Mix

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[59] Calculations are based on annual member month projections. PwC adjusted the values to reflect the removal of the PEBB account, which was announced in August 2003.

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Future Participation in Public Programs

Premera has accounts with a number of public programs, including Federal and State employee health benefits and those for low income populations, including Healthy Options, the Medicaid managed care program and the State Child Health Insurance Program (CHIP) for children under 19, and the Basic Health Plan (BHP), the expansion program for low income populations who do not qualify for the Medicaid or CHIP public insurance programs.

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Federal Employees Program

Premera participates in the Federal Employees Program (FEP) through the national Blue Cross Blue Shield Association.

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State Public Employees Benefits Board

Premera announced that it will withdraw from the PEBB account as of January 1, 2004.

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Medicare

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Healthy Options and Children's Health Insurance Program

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Basic Health Plan

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Summary of Premera Blue Cross Performance

Tables 7-18 and 7-19 summarize the average operating margins for Premera Blue Cross and the Washington state operations as reflected in the historical performance (1997 to 2002) and in the current financial projections (2003 to 2007).

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8. COMPARISON OF PREMERA BLUE CROSS TO OTHER BLUE CROSS BLUE SHIELD PLANS

This section discusses general operating statistics and performance of Premera Blue Cross compared to other Blue Cross and Blue Shield (BCBS) plans. This comparison includes system wide results from the national Blue Cross Shield Association and peer comparison to neighboring Blue Cross and Blue Shield plans and those that are generally comparable in size, as measured by annual premium and medical membership. Most data for 1998 to 2002 was taken from summaries prepared by A.M. Best, the rating service, using the health annual statement as submitted to state Departments of Insurance and available from the National Association of Insurance Commissioners (NAIC).

National Association of Blue Cross and Blue Shield Plans

Over the period 1997 to 2002, the national Blue Cross and Blue Shield system saw improved financial and operating results. Premiums increased at a compound annual rate of 13.3%, greater than the 12.8% compound rate of increase for medical claims costs. These produced a 2% decrease in the medical loss ratio in the five-year period. Administrative ratios declined from 12.5% to 11.1%, further boosting underwriting gains. Gains from operations were aided by gains from subsidiary operations and helped to offset declines in investment income.

System wide membership grew at an annual average of 4.3%. By 2002, the Blue Cross and Blue Shield Association plans insured more than 85 million Americans, over 20% of the national population. System operating statistics are presented in Tables 8-1 and 8-2 below.

Table 8-1
National Blue Cross and Blue Shield System
Financial Highlights Summary: 2002-2007
(In millions)

	1997	1998	1999	2000	2001	2002
Net subscriber revenue	$87,096	$94,857	$109,014	$126,088	$143,181	$162,780
Claims expense	$77,216	$84,048	$95,798	$110,600	$125,131	$141,026
Admin. expense	$10,918	$11,768	$13,109	$14,709	$16,163	$18,097
Underwriting gain/(loss)	**($1,038)**	**($959)**	**$107**	**$779**	**$1,887**	**$3,657**
Investment income/(expense)	$2,171	$2,479	$2,001	$2,197	$1,841	$1,153
G/(L) from subsidiaries	($24)	$1	($230)	$137	$98	$709
Federal income tax	$20	($118)	($560)	($684)	($994)	($1,566)
Net gain/(loss) after taxes	**$1,129**	**$1,403**	**$1,318**	**$2,429**	**$2,832**	**$3,953**

Source: Blue Cross and Blue Shield Association. Personal Communication.

Table 8-2
National Blue Cross and Blue Shield System
Financial Highlights Summary: 2002-2007
Operating Metrics

Metric as % Net Revenue	1997	1998	1999	2000	2001	2002
Medical loss ratio	88.7%	88.6%	87.9%	87.7%	87.4%	86.6%
Administrative ratio	12.5%	12.4%	12.0%	11.7%	11.3%	11.1%
Underwriting gain/(loss)	(1.2)%	(1.0)%	0.1%	0.6%	1.3%	2.2%
Investment income	2.5%	2.6%	1.8%	1.7%	1.3%	0.7%
G/(L) from subsidiaries	(0.0)%	0.0%	(0.2)%	0.1%	0.1%	0.4%
Net gain/(loss) after taxes	1.3%	1.5%	1.2%	1.9%	2.0%	2.4%
Members in millions	69.0	71.4	74.9	80.1	82.6	85.3

Source: Blue Cross Blue Shield Association

Peer Blue Cross and Blue Shield Plans

Two sets of Blue Cross and Blue Shield plans were selected for a peer group comparison. The first is a comparison to Regence Blue Cross and Blue Shield plans that operate in Washington and the adjacent states of Oregon and Idaho. This comparison provides a benchmark for operational and financial results in geographically similar markets. The second comparison is to a broader set of Blue Cross and Blue Shield plans throughout the country. These are selected on the basis of comparable size, but are not assumed to be necessarily similar in other characteristics, such as health plan competition and market position.

Comparison of Premera BC to BCBS Plans in Neighboring States

The Regence Group is an affiliation of plans that operate in the State of Washington and other states in the geographic Northwest. These include Regence Blue Shield of Washington with the service mark in western Washington and a non-Blues brand in the eastern counties, the statewide plans, Regence Blue Cross Blue Shield of Oregon, and Regence Blue Shield of Idaho. There is a second Blues plan in Idaho, Blue Cross of Idaho Health Service, which also operates statewide. The information for Premera includes operations only in Washington and Alaska[60],

Premera Blue Cross, Regence Blue Shield of Washington, and Regence Blue Cross and Blue Shield of Oregon are quite similar with annual premium revenue of $1 to $2 billion. The two Idaho plans are less than half that size, with less than $500 million of annual premium revenue. The following tables present a five-year comparison of operating results for a number of common measures. During the period 1998-2002, Premera moved to increased profitability, with premium growth and total net income exceeding the neighboring plans. However, overall operating metrics are quite similar for Premera and the two large Regence plans.

Net Premium Written

Comparisons of net premium written (NPW)[61] in Table 8-3 for the period 1998–2002 show that Premera Blue Cross is the largest of this peer group and produced greater year-to-year

[60] Therefore these dollars and metrics will differ from results for the total corporate Premera Blue Cross.

[61] Defined by AM Best as Premium and Other Premium revenue. It is also referred to as operating revenue and excludes investment income and other non-premium revenue.

gains than the neighboring BCBS plans.[62] It had a five-year average growth rate of 12.0%. Regence BCBS Oregon grew slightly faster, showing an average annual premium growth of 12.6%, while Regence BS Washington reported a 4.8% compound premium growth.

Table 8-3
Regional Peer Group Comparison
Net Premium Written (In Millions)

Company Name	1998	1999	2000	2001	2002
Premera Blue Cross	$1,371	$1,517	$1,771	$2,075	$2,157
Regence BC/BS of Oregon	$846	$948	$1,016	$1,084	$1,358
Regence BS Washington	$1,250	$1,488	$1,555	$1,447	$1,508
Regence Blue Shield of Idaho	$271	$310	$380	$406	$451
BC of Idaho Health Service	NA	$277	NA	$343	$456

Source: A.M. Best's Key Rating Guide – L/H Vol.2003

Net Income

Over the period 1998-2002, Premera showed improved net income, moving from a gain of $5.5 million in 1998 to $38.5 million in 2001, before dropping to $7.5 million in 2002. Regence BS Washington shows $39.9 million net operating gain in 2001, and also declined, dropping to $10.4 million in 2002. In contrast, Regence BCBS Oregon demonstrates almost the reverse trend of Premera, going from $17.7 million net income to a loss of ($6.1) million in 2001, before rebounding to $10.4 million in 2002.

Table 8-4
Regional Peer Group Comparison
Net Income After Investment and Taxes ($000s)

Company Name	1998	1999	2000	2001	2002
Premera Blue Cross	$5,503	$34,679	$31,157	$38,505	$7,525
Regence BC/BS of Oregon	$17,784	$15,689	$3,471	($6,101)	$10,366
Regence BS Washington	$7,096	$12,040	$21,193	$39,885	$10,442
Regence Blue Shield of Idaho	$4,774	$3,752	$4,223	$2,106	($3,786)
BC of Idaho Health Service	NA	$3,873	NA	$1,800	$4,968

Source: A.M. Best's Key Rating Guide – L/H Vol.2003

62 The report uses the AM Best reported values as a consistent method of comparing operating results across Blue Cross and Blue Shield plans.

Medical Loss Ratio

Medical loss ratio (MLR), defined as benefits paid as a percent of net premium, decreased from 1998 to 2002 for Premera and the two large Regence plans. The Premera medical loss ratio decreased from 89.4% to 84.9% over the time period; Regence BCBS Oregon decreased from 90.2% to 87.0% while Regence BS Washington was lower, decreasing from 86.0% to 82.9%. On a weighted average basis, Regence Blue Shield achieved the lowest MLR of 84.7% over the five year time period. Premera was next at 86.5% and Regence BCBS was higher at 88.5%. The smaller Idaho plans were at both ends of this range.

Table 8-5
Regional Peer Group Comparison
Benefits Paid as a Percent of Net Premium Written (Medical Loss Ratio)

Company Name	1998	1999	2000	2001	2002
Premera Blue Cross	89.4%	89.0%	85.6%	85.2%	84.9%
Regence BC/BS of Oregon	90.2%	88.0%	89.7%	88.2%	87.0%
Regence BS Washington	86.0%	86.4%	86.4%	82.1%	82.9%
Regence Blue Shield of Idaho	87.2%	86.7%	85.8%	85.2%	88.0%
BC of Idaho Health Service	NA	85.7%	NA	83.2%	83.9%

Source: A.M. Best's Key Rating Guide – L/H Vol.2003

Administrative Expense Ratio

The administrative ratio, defined as commissions and expenses as a percent of net premium income, ranged from 13% to 17% for the plans in 2002. Premera showed a slight decrease over the period and averaged 14.3% administrative expense ratio. This was higher than Regence BCBS Oregon at 13.6% and substantially lower than the 16.9% average reported by Regence BS Washington.

Table 8-6
Regional Peer Group Comparison
Commission and Expenses as a Percent of Net Premium Written
(Administrative Expense Ratio)

Company Name	1998	1999	2000	2001	2002
Premera Blue Cross	14.9%	15.1%	13.8%	14.0%	14.0%
Regence BC/BS of Oregon	12.9%	14.7%	13.0%	14.2%	13.3%
Regence BS Washington	18.4%	17.3%	15.5%	16.5%	17.1%
Regence Blue Shield of Idaho	14.9%	15.5%	14.3%	15.6%	14.6%
BC of Idaho Health Service	NA	16.1%	NA	15.7%	15.6%

Source: A.M. Best's Key Rating Guide – L/H Vol.2003

Net Operating Gain as a Percentage of Total Revenue

All plans, except for BC Idaho Health Services, show at least one year of negative percentage net operating gain (NOG) in the period 1998 to 2002.[63] When compared to the Net Income values, which are positive for the same plans for most of the years, the years with negative NOG values indicate losses on the insurance business that were offset by investment income or other non-premium revenue. Premera shows approximately a 3% improvement in NOG from 1998 to 2002, moving from negative (-1.0%) to positive 1.9% for an average of 1.4%, the highest among the three large plans. Regence BS Washington appears to have offset operating losses in 1998 and 1999 with other revenue to maintain positive net income over the period. Regence BCBS Oregon shows losses for each year from 1998 to 2001. The plan reduced the percentage loss after 1998, but continuing operating losses were not fully covered by other revenue and the plan experienced operating and net income losses through 2001 until positive NOG in 2002.

[63] The Net Operating Gain as a percent of total revenue is the percentage calculated before investment gain (loss) and taxes.

Table 8-7 Regional Peer Group Comparison Net Operating Gain as a Percentage of Total Revenue (Before Taxes)					
Company Name	**1998**	**1999**	**2000**	**2001**	**2002**
Premera Blue Cross	-1.0%	2.3%	1.4%	1.6%	1.9%
Regence BC/BS of Oregon	-1.4%	-0.2%	-0.7%	-0.5%	1.7%
Regence BS Washington	-2.6%	-1.7%	0.1%	2.6%	1.8%
Regence Blue Shield of Idaho	-1.0%	-0.4%	0.9%	0.6%	-0.8%
BC of Idaho Health Service	NA	1.4%	NA	0.9%	1.5%
Source: A.M. Best's Key Rating Guide – L/H Vol.2003					

Premera Blue Cross only; as reported under NAIC guidelines

Comparison of Premera BC to BCBS Peer Group Plans

In addition to the Regence plans in Washington and Oregon, we identified 12 Blue Cross Blue Shield plans with a premium range from $1 to $4 billion in 2002. Premera Blue Cross premium is in the middle of the group at $2 billion in annual revenue. The peer group includes a number of BCBS plans that are part of a for-profit health insurer or that have recently been considered applicants for a for-profit conversion.[64] The comparison between Premera and this peer group uses the same metrics that were reviewed in the preceding section. In general, Premera Blue Cross reports historical performance in the mid-range of this peer group.

Net Premium Written

Comparisons of net premium written (NPW) for the period 1998–2002 shows that Premera Blue Cross has grown net premium at a 5 year rate that is in the lower half of the peer group. The Premera compound annual growth rate (CAGR) computed on net premium written for the period 1998 to 2002 was 12.0%; the CAGR for the period 2000 to 2002 was slightly lower at 10.4%. Eight other BCBS plans exceeded this performance. Four plans had compound growth rates greater than 20%. BCBS of Massachusetts has grown from $1.9 billion to $3.8 billion in premium over the past four years, a CAGR of 25.6%, and BCBS Healthcare of Georgia, now part of Wellpoint Health Networks, has increased premium from

[64] BCBS Healthcare Plan of Georgia and BCBS of Georgia are part of the Cerulean Co. that was acquired by Wellpoint. CareFirst of Maryland and BCBS of North Carolina both filed for profit conversion in their states (see comment in Section X); and Horizon HealthCare of New Jersey was considered a candidate for conversion but recently announced that it will not file an application.

$510,000 to $1.3 billion, for a CAGR of 26.4%. All plans but one[65] showed premium increases, four showed single digit increases, six had increases that ranged from 10% to 20% and four had average annual premium growth in excess of 20%.

Table 8-8
National Peer Group Comparison
Net Premium Written (In Millions) and Compound Annual Growth Rate

	Data Year					5 Yr.	2000-02
BCBS Plan Name	1998	1999	2000	2001	2002	CAGR	CAGR
Anthem Health Plans of KY	$800	$906	$1,026	$1,155	$1,317	13.27%	13.28%
BC BS Healthcare of GA	$511	$665	$875	$1,090	$1,305	26.44%	22.10%
BC BS of AL	NA	$1,844	$2,015	$2,204	$2,353	8.46%	8.07%
BC BS of FL	$1,601	$1,785	$2,107	$2,397	$2,662	13.55%	12.39%
BC BS of GA	$674	$807	$967	$1,176	$1,505	22.24%	24.76%
BC BS of MA	NA	$1,942	$2,752	$3,574	$3,844	25.57%	18.18%
BC BS of MN	$868	$1,080	$1,231	$1,395	$1,546	15.52%	12.08%
BC BS of NC	$1,352	$1,361	$1,454	$1,677	$2,085	11.44%	19.76%
BC BS of TN*	$1,648	$1,770	$2,159	$1,247	$1,445	-3.23%	-18.18%
CareFirst of Maryland Inc.	$967	$1,047	$1,111	$1,291	$1,388	9.45%	11.77%
Hawaii Medical Service Assn.	$995	$1,023	$1,133	$1,141	$1,283	6.56%	6.43%
Horizon Healthcare of NJ	$613	$880	$864	$1,089	$1,445	23.91%	29.30%
Premera Blue Cross	$1,371	$1,517	$1,771	$2,075	$2,157	12.00%	10.36%
Regence BC/BS of Oregon	$846	$948	$1,016	$1,084	$1,358	12.55%	15.61%
Regence Blue Shield	$1,250	$1,488	$1,555	$1,447	$1,508	4.81%	-1.50%

Source: A.M. Best's Key Rating Guide – L/H Vol.2003

** The decline for BCBS Tennessee appears to be due to a change in the reporting of premium equivalent for ASC business. Revised numbers could not be obtained. Personal communication with plan*

Net Income

For 2002, Premera Blue Cross reported net income of $7.5 million, which places the company at the bottom, exceeding only the Hawaii Medical Service Association that reported losses. Six plans had 2002 net income in excess of $50 million. Using a four year weighted average performance, the peer group midpoint is approximately $35 million annual net

[65] The decline for BCBS Tennessee appears to be due to a change in the reporting of premium equivalent for ASC business. Revised numbers could not be obtained. Personal communication with plan.

income and Premera is somewhat below that, at $28.7 million. Because of the drop in net income in 2002, the ranking drops if only the past two years results are compared. The peer group average was $42.5 million while the Premera average was $23 million. The three most profitable plans in the peer group, BCBS of Florida, Massachusetts, and Georgia, averaged over $85 million net income in 2001 to 2002.

Table 8-9
National Peer Group Comparison
Net Income After Investment and Taxes (In Millions)

BCBS Plan Name	1998	1999	2000	2001	2002
Anthem Health Plans of KY	$37.2	($12.6)	$39.7	$15.6	$75.1
BC BS Healthcare of GA	$11.4	$14.4	$21.6	$22.8	$19.0
BC BS of AL	NA	$15.9	$17.6	$52.2	$42.1
BC BS of FL	$46.5	($0.6)	($19.9)	$69.4	$166.3
BC BS of GA	$15.1	$33.2	$43.9	$65.5	$108.3
BC BS of MA	NA	$60.4	$109.0	$103.6	$84.6
BC BS of MN	$247.6	$12.7	$42.1	($39.3)	$47.7
BC BS of NC	$11.0	($5.6)	$51.9	$85.2	$17.8
BC BS of TN	$33.6	$53.3	$52.7	$40.2	$96.7
CareFirst of Maryland Inc.	$5.1	$40.7	$43.4	$23.1	$22.2
Hawaii Medical Service Assn.	$10.1	$35.9	$4.5	$19.1	($40.5)
Horizon Healthcare of NJ	($47.0)	$12.9	$20.2	$26.9	$51.3
Premera Blue Cross	$5.5	$34.7	$31.2	$38.5	$7.5
Regence BC/BS of Oregon	$17.8	$15.7	$3.5	($6.1)	$10.4
Regence Blue Shield	$7.1	$12.0	$21.2	$39.9	$10.4

Medical Loss Ratio

Medical loss ratio decreased from 89.4% to 84.9% for Premera in the period 1998 to 2002. On a weighted average basis, Premera achieved a MLR of 86.5% over the five year time period, slightly higher than the peer group average of 84.3%. The Premera MLR is also higher than the medical ratios reported by Anthem, Georgia, and North Carolina, the plans that are part of for-profit operations or that have considered for profit conversions. At the same time, it is lower than CareFirst, a plan that recently attempted to convert to for-profit, and lower than Horizon New Jersey, a plan that had considered filing for conversion.

Table 8-10
National Peer Group Comparison
Benefits Paid as a Percent of Net Premium Written (Medical Loss Ratio)

BCBS Plan Name	1998	1999	2000	2001	2002	Wtd. Avg.
Anthem Health Plans of KY	83.6%	84.5%	80.5%	82.3%	80.8%	82.1%
BC BS Healthcare of GA	84.5%	84.8%	84.1%	84.2%	83.9%	84.2%
BC BS of AL	NA	94.6%	94.5%	88.9%	91.4%	92.2%
BC BS of FL	82.8%	84.6%	84.8%	83.7%	79.4%	82.9%
BC BS of GA	88.0%	88.7%	88.6%	86.9%	82.8%	86.4%
BC BS of MA	NA	85.2%	84.9%	85.2%	86.1%	85.4%
BC BS of MN	101.2%	86.3%	85.3%	83.1%	82.9%	86.6%
BC BS of NC	86.6%	84.0%	79.1%	80.6%	80.3%	81.9%
BC BS of TN	88.9%	86.1%	88.0%	86.8%	82.9%	86.7%
CareFirst of Maryland Inc.	87.9%	87.7%	88.8%	84.5%	85.6%	86.7%
Hawaii Medical Service Assn.	95.1%	92.8%	96.1%	93.9%	93.8%	94.3%
Horizon Healthcare of NJ	100.0%	83.8%	83.9%	84.9%	87.3%	87.1%
Premera Blue Cross	89.4%	89.0%	85.6%	85.2%	84.9%	86.5%
Regence BC/BS of Oregon	90.2%	88.0%	89.7%	88.2%	87.0%	88.5%
Regence Blue Shield	86.0%	86.4%	86.4%	82.1%	82.9%	84.7%

Administrative Expense Ratio

The administrative ratio, defined as commissions and expenses as a percent of net premium income, ranged from 7.2% to 17.6% for the plans in 2002. Premera showed some decrease over the 1998-2002 period and a weighted average 14.3% administrative expense ratio. The Premera average is above the peer group weighted average of 13.1%.

When the Premera administrative ratio is compared to the peer group plans that are for-profit or have recently considered conversion, Premera operates in comparable range. Horizon (NJ) and CareFirst (MD) report administrative expenses at least a point lower. However, Anthem of Kentucky and BCBS Healthplan of Georgia have higher administrative expense ratios.

Table 8-11
National Peer Group Comparison
Administrative Expense Ratio

BCBS Plan Name	1998	1999	2000	2001	2002	Wtd. Avg.
Anthem Health Plans of KY	18.3%	18.1%	16.5%	14.0%	13.7%	15.8%
BC BS Healthcare of GA	15.2%	14.8%	14.9%	15.0%	15.3%	15.1%
BC BS of AL	NA	6.4%	5.9%	9.1%	7.2%	7.2%
BC BS of FL	17.4	16.6%	15.8%	13.1%	12.7%	14.8%
BC BS of GA	12.5%	12.1%	11.7%	9.5%	9.9%	10.8%
BC BS of MA	NA	13.9%	12.2%	12.3%	10.6%	12.0%
BC BS of MN	23.5%	15.7%	14.2%	14.3%	12.7%	15.4%
BC BS of NC	17.9%	18.8%	19.5%	16.2%	16.4%	17.6%
BC BS of TN	11.3%	12.1%	10.6%	11.7%	10.6%	11.2%
CareFirst of Maryland Inc.	12.3%	8.7%	9.2%	14.8%	14.2%	12.1%
Hawaii Medical Service Assn.	9.1%	9.6%	8.7%	8.2%	8.9%	8.9%
Horizon Healthcare of NJ	11.7%	15.4%	14.7%	13.2%	9.7%	12.6%
Premera Blue Cross	14.9%	15.1%	13.8%	14.0%	14.0%	14.3%
Regence BC/BS of Oregon	12.9%	14.7%	13.0%	14.2%	13.3%	13.6%
Regence Blue Shield	18.4%	17.3%	15.5%	16.5%	17.1%	16.9%

Net Operating Gain as a Percentage of Total Revenue

Many of the plans report some years of operating losses during the five-year period, and in general show operating gain for 2000 and 2002.[66] The Premera improvement from 1998 to 2002, a move from negative (-1.6%) to positive 1.9% NOG, is a weighted average of 1.4%. This is somewhat below the peer group average of 1.9%. However, this is lower than the figures reported by the plans that are part of for-profit organizations or that have recently considered conversion. Anthem KY, BCBS Georgia, CareFirst and Horizon all report greater percentage gains on operations.

[66] The Net Operating Gain as a percent of total revenue is the percentage before investment and taxes.

Table 8-12
National Peer Group Comparison
Percent Net Operating Gain to Total Revenue (Before Taxes)

BCBS Plan Name	1998	1999	2000	2001	2002	Wtd. Avg.
Anthem Health Plans of KY	0.6%	-1.0%	4.1%	1.1%	5.4%	2.3%
BC BS Healthcare of GA	2.1%	2.1%	2.4%	2.0%	1.4%	1.9%
BC BS of AL	NA	0.0%	0.3%	2.5%	2.1%	1.3%
BC BS of FL	1.5%	-0.8%	-0.8%	2.9%	6.9%	2.3%
BC BS of GA	1.2%	3.2%	3.8%	5.3%	7.1%	4.7%
BC BS of MA	NA	2.7%	4.1%	3.5%	3.7%	3.6%
BC BS of MN	17.6%	-0.2%	1.9%	-1.1%	5.3%	3.9%
BC BS of NC	-2.6%	-1.3%	1.6%	2.3%	2.0%	0.6%
BC BS of TN	1.1%	2.5%	2.1%	2.8%	6.6%	2.9%
CareFirst of Maryland Inc.	0.4%	3.7%	3.7%	1.5%	2.0%	2.3%
Hawaii Medical Service Assn.	-1.4%	-0.2%	-2.4%	1.4%	-1.6%	-0.9%
Horizon Healthcare of NJ	-7.4%	1.4%	2.3%	2.4%	3.5%	1.3%
Premera Blue Cross	-1.0%	2.3%	1.4%	1.6%	1.9%	1.4%
Regence BC/BS of Oregon	-1.4%	-0.2%	-0.7%	-0.5%	1.7%	-0.1%
Regence Blue Shield	-2.6%	-1.7%	0.1%	2.6%	1.8%	0.1%

9. QUANTIFYING THE POTENTIAL ECONOMIC IMPACT OF PREMERA CONVERSION: RESULTS OF ECONOMIC MODEL

Background

Economists and actuaries at PricewaterhouseCoopers developed a model to assess the potential economic impact on insurance premium increases, health care payments to providers, and the resulting operating margins by line of business under alternative scenarios of application of Premera market power. This model was developed to estimate the level of change in premium and/or provider payments that might be required in the state of Washington for Premera to meet market based target operating margins across all lines of business and to support aggregate corporate operating margins at a level to match profitability levels of for profit publicly traded health insurance companies.

Model Objective

The model was developed to estimate the effects on Premiums, Healthcare Costs, and Enrollment if Premera follows either of the following strategies:

(1) Allow the competitive healthcare trends to dictate long run operating margins.

(2) Adjust healthcare premiums and costs to levels more favorable to Premera than healthcare trends in the attempt to generate greater long term operating margins.

The model identifies the lines of business and region combinations in which Premera's market power may allow it to affect premiums and costs, and those lines of business and region combinations in which Premera is likely to be a price taker. By permitting premium increases and/or health care costs to vary from competitive market assumptions in the counties in which Premera is determined to have market power, it is possible to estimate how much Premera's premiums and healthcare costs need to change to achieve a target operating margins.

The base model uses the Premera projection model assumptions to test the situation where Premera accepts, due to competition, prices dictated by healthcare trends.[67] To estimate how much premium and/or health care costs must change it assumes a target operating margin for the non-competitive combinations and analyzes the overall operating margins that Premera can obtain. The model also analyzes the Premiums, Healthcare Costs, and the resulting Enrollments that achieve the target operating margin in the non-competitive combinations. These results are then compared.

Theory and Methodology

The model uses data provided by Premera Blue Cross, supplemented with information on health care market conditions in the state of Washington. The information in the model includes:

- Premera financial information by line of business by county[68] for the state of Washington during the period January 2001 through November 2002. This consisted of summary data from billing, membership and claims systems and included, by line of business and county, 1) average enrollment or member months, 2) premium revenue, and 3) claims paid by major service category and in total.

- Premera's projection model by line of business for 2003 to 2007. This provided assumptions of enrollment change, trend in premium and health care costs, allocation of administrative expense and estimated operating margins for the selected lines of business in the Washington market business units.

- Market share information by line of business by county from Washington health plan Form B enrollment filings to the Office of the Insurance Commissioner in 2002 for the year ended December 2001.

- Health care supply factors, including hospital bed and physician to population ratios calculated from information available from professional associations and economic and demographic statistics from the US Bureau of the Census, the Washington Department of Finance, and other state agency sources.

- Estimates of health care market performance parameters based on research reported in the healthcare and economic literature.

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[67] A more detailed methodological documentation, including the mathematical description of the problem and its algebraic solution, has been prepared and is available upon request.

[68] The model uses 39 counties in Washington and 1 Other to aggregate Premera business in outside of the state.

The Premera data on Revenue, Claims, and Member Months by sub-lines of business and county was aggregated into five lines of business: Individual, Regulated Small (1-50 employees), Small/Mid size (51-99 employees), Large, and Other, including government business.[69]

Premera is assumed to have the ability to affect premiums, and possibly health care costs, in the lines of business or regions where it has "market power." In contrast, Premera is assumed to accept market trend in healthcare premiums and health care costs in lines of business or regions where it does not have market power.

The company is presumed to have the ability to affect premium when the Premera market share is greater than a threshold value[70] Market share power is analyzed by geography and by line of business. Premera is presumed able to exert market power in every county/business line combination for which the market share criteria are met. These counties are aggregated according to business line.

Using the Premera historical data and the Premera financial projection model assumptions, the economic model calculates the Per Member Per Month (PMPM) values for premium and health care costs, average annualized utilization and cost trend for the projection period, and an estimated administrative cost PMPM by line of business with separate components for premium taxes plus commissions and for general administrative expense.

The model projects changes in premium revenue, healthcare costs (HCC), other revenue, premium tax and sales costs, general administrative costs, and enrollment using compound average annualized trends for the counties and business lines that match the corporate projection model. The trend assumptions are presented in Table 9-1.

69 Individual included Individual LifeWise WA and Individual sub-lines of business. The Regulated Small includes CR 1-50 HMO E WA, CR 1-50 PPO E WA, and CR 1-50 PPO W WA sub-lines of business. The Small line of business includes CR 51-99 POS E WA, CR 51-99 PPO E WA, and CR 51-99 PPO W WA. Large Group is 100+ MPP E WA, 100+ MPP W WA, 100+ RETENTION E WA, 100+ RETENTION W WA; ASSOCIATIONS, ASSOCIATIONS LW WA, PEBB GRP MED SUP, PEBB POS E WA, and WEA. Large line of business. The sub-lines of business 100+ HMO E WA, 100+ POS W WA; BHP, HEALTHPLUS COMMERCIAL, HEALTHY OPTIONS, MED SUP WA, and NATIONAL ACCOUNTS form the Other line of business. ASC business is excluded from the analysis.

70 Some degree of market power over healthcare costs is presumed whenever market power over premiums exists. We studied the likelihood that market power over costs also exists to provide an understanding of the extent to which greater operating margins may be created through movements in costs rather than premiums.

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If Premera increases premiums above the level indicated by the base trend, existing enrollees may drop out of the Premera plan and choose to purchase healthcare insurance from a competing firm or become uninsured; potential new members may not enroll.

The ability and willingness of consumers to respond to changes in premiums by switching healthcare plans depends in part on the market structure. If Premera has market power in a region or line of business, the company may be able to increase premiums above the base trend without a significant loss of customers to competitors. If there is sufficient competition in the market, an increase in price above the base trend may lead a relatively large number of consumers to switch insurers or to drop coverage. In all cases, ability and willingness to pay for health insurance coverage limits the health plans' ability to raise prices to some extent.

The model captures the price and quantity interactions in a measure called "elasticity".[71] The responsiveness of members to changes in premiums, known as the elasticity of demand, is defined as the percentage change in enrollment induced by a given percentage change in premiums. The model tested two elasticity measures. An elasticity of 0.5 is where a 1.0 percent increase in premiums leads to a 0.5 percent decrease in enrollment. An elasticity of

[71] Several studies have been conducted to measure the price elasticity of demand for health insurance between competing insurance firms. Cutler and Reber (1996) report an elasticity of –0.3 and –0.6 while studying the enrollment changes due to a change in out-of-pocket premiums. In their study, Feldman et al. (1989) demonstrate that price elasticities range from –0.53 to –0.15 depending on the market share of the insurance firm and the share of the competitors. Plans with small enrollments have larger elasticities as compared to plans with larger enrollments. Hosek et al. (1993) calculated an elasticity of –0.6 for a choice between military and civilian health plan. Royalty and Solomon (1998) report an elasticity of –1.0 to –1.8 in a study of Stanford University employees' response to changes in premiums. A detailed account of these studies can be found in an article by Jeanne S. Ringel, et al. on "The Elasticity of Demand for Health Care – A Review of the Literature and Its Applications to the Military Health System."

1.05 indicates that a 1.0 percent increase in premiums leads to a 1.05 percent decrease in enrollment.[72]

The model sets operating margin targets by business line and permits increases in premium and/or decreases in costs that are different than baseline for those counties and lines of business where Premera is presumed to have market power. This produces an estimate of the change in premium, health care cost and enrollment in those markets that would be required to meet overall line of business financial targets. The line of business estimates are combined to compute the overall corporate operating margins.

The model is run twice. The first run uses the baseline trends in the Premera projection model for all geographies and lines of business. The second run uses industry guidelines to set operating margin targets for the end of the projection period and allows regions and lines of business where Premera has market power to exceed the baseline trends.

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The difference in results between the two runs produces a measure of the degree that Premera may need to change premiums and costs beyond the projected trend in the lines of business to meet the overall target margins.

Model Results and Sensitivity

Baseline Results

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[72] An elasticity of less than 1 indicates that the consumer response is less than the change in price and is considered "inelastic". When the elasticity is greater than 1, the consumer change is greater than the change in price and is considered "elastic". Highly competitive markets are characterized by elastic demand.

[73] Results will not exactly match the Premera Washington state projection model because the economic model starts from a base of county level information that is adjusted to 2002 results, does not include all products within each line of business, and applies average annual trend factors for the five year projection period.

Counties Grouped by Market Power By Line of Business

Enrollment data reported to the state was used to compute market share and to identify those counties and lines of business where Premera can be considered to have market power. The economic model combines the counties that have market power over premiums and costs in each line of business using the market share criteria and allows those counties to set premiums greater than projected trend and/or to set the increase in health care cost below the projected trend. Premera projected trends are used for all counties and lines of business where the company does not have market power.

The county level model compares results using a Premera market share criteria of 65%.[74] Regardless of the choice of market share assumed to indicate market power, the model results indicate that Premera would have to achieve margins in excess of 20% for Individual business, 10% for Regulated Small Group and 30% for the Small/Mid size groups in the subset of counties in which it has market power in order to approach the statewide line of business operating margins. The summary of results indicates that target operating margins for the counties do not vary substantially at these relatively high levels of market share. The results are also not very sensitive to use of 0.5 or 1.05 for the measure of price elasticity.

65% Market Share Criteria

The number of counties with market power in the Individual, Regulated Small Group, Small, and Large lines of business when the lower limit on market share is 65% are 16, 18, 13, and 13 respectively.

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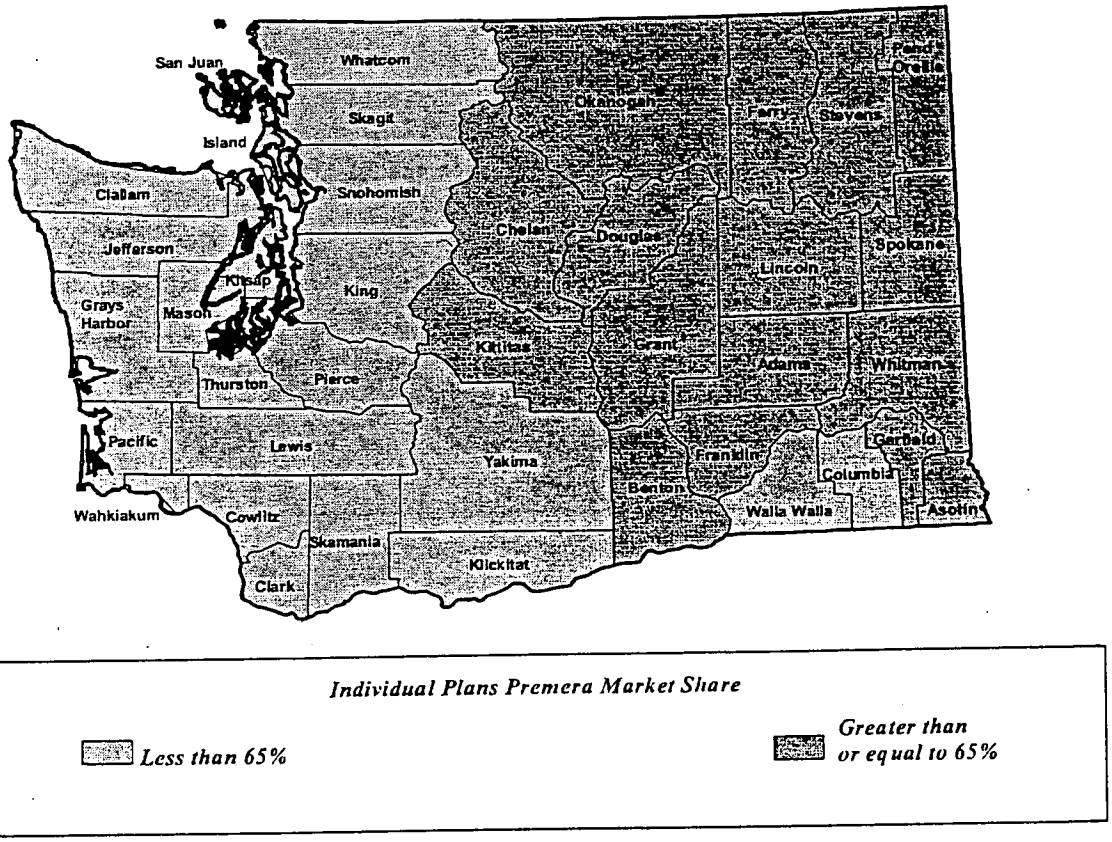
.[75] In the aggregate, by 2007 these increases would push average premium to over $300 per person per month for these lines of business, and affect an estimated 96,800 members in 16 to 18 counties.

[74] The model was also tested in prior runs at the 60%, 70%, 75% and 85% share of market power. The results did not differ substantially.

[75] For the Small/Mid-Size Market, operating margins would have to be pushed to 34.5% in the counties where Premera has market power. However, it is assumed that this cannot be accomplished by raising premium; target margin would have to be achieved by reduction in costs.

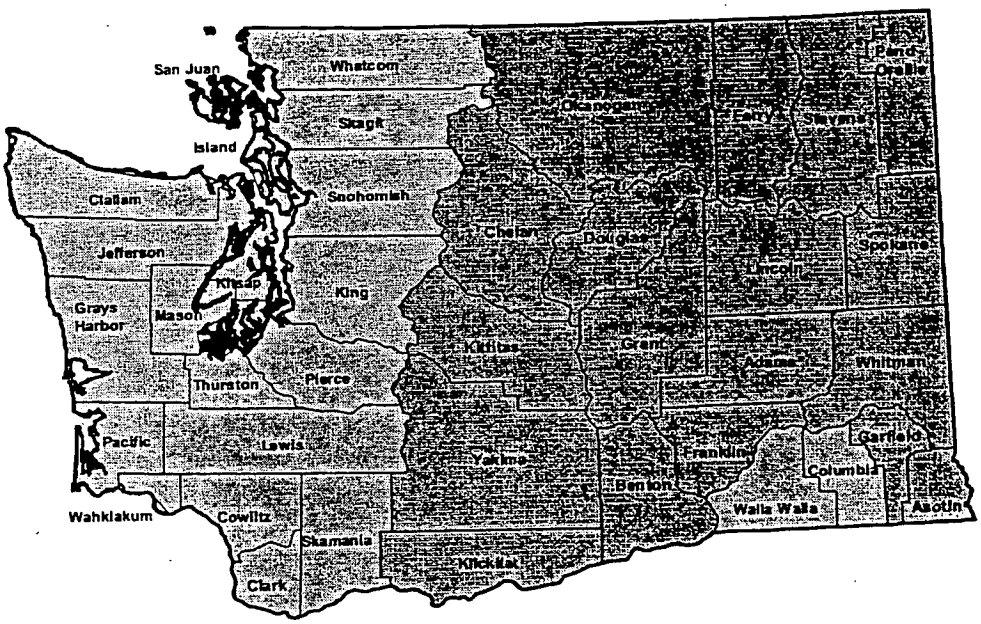
These results are summarized in Table 9-2. Figures 9-1 and 9-2 are maps of the counties that meet the Premera market share criteria of 65% for the Individual and Regulated Small Group lines of business.[76]

Figure 9-1
Premera Blue Cross
Washington State
Individual Market – Counties Greater than 65% Market Share



[76] We have not shown maps for other lines of business because it is assumed that these markets are sufficiently competitive that a health plan cannot raise premiums above market levels.

Figure 9-2
Premera Blue Cross
Washington State
Regulated Small Group Market – Counties Greater than 65% Market Share



Regulated Small Group Premera Market Share

Less than 65%

Greater than or equal to 65%

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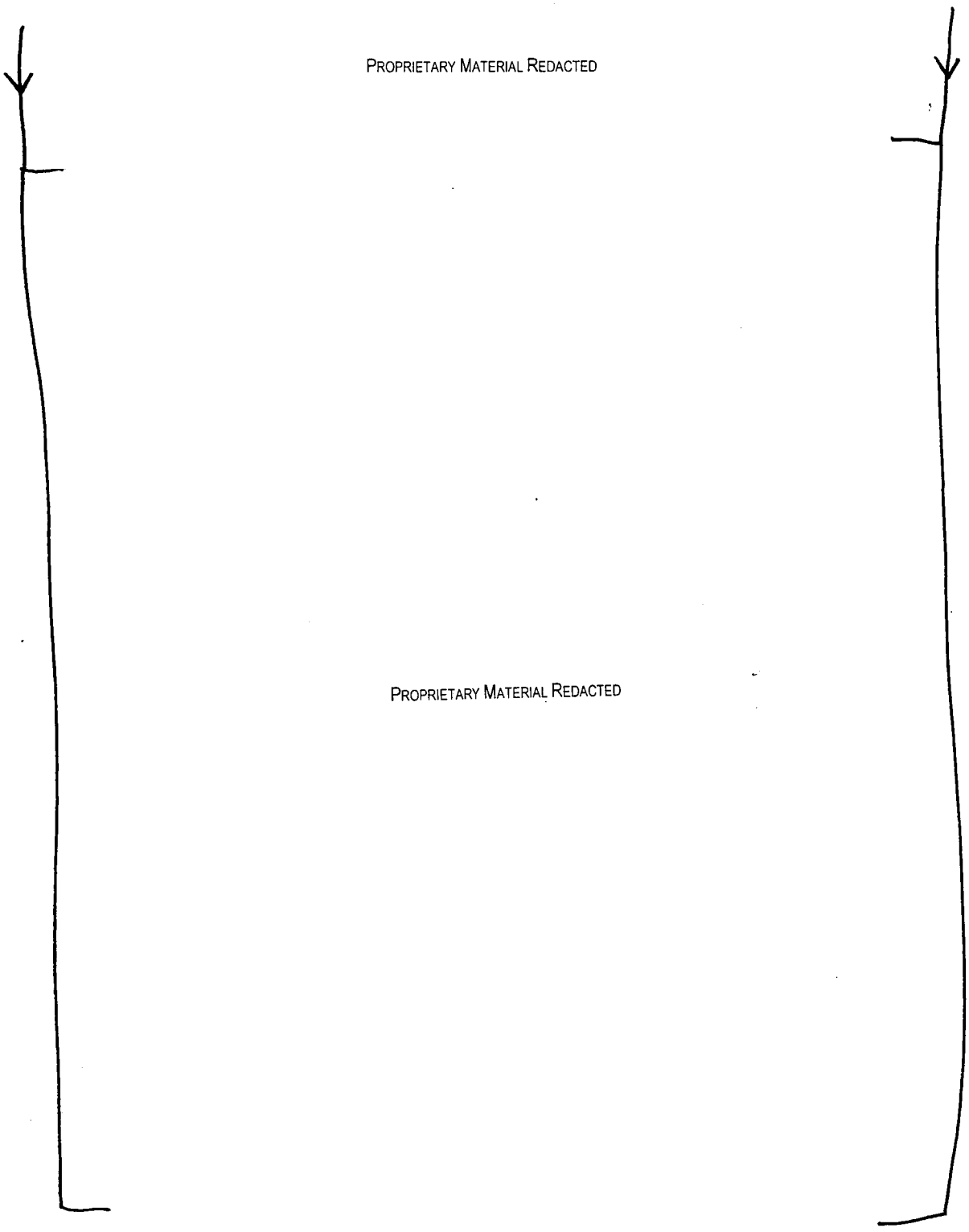

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Implications of Model Results

Table 9-4 extracts the results to permit a comparison of the size of the population that could potentially face increases in premium that exceed the general health care trend. Regardless of whether changes are made to premium, provider payments or some combination of the two, the population groups affected are largely the same. However, if changes are largely targeted to provider payment rates, a broader population in the geographic is affected. Therefore, the rate of change may be less. Statewide, approximately 17% of the projected enrollment lives in the counties where Premera has substantial market share. Of that, 10% of the enrollment, an estimated 97,000 to 98,000 people, are projected to be in individual and small group products in areas that could potentially face a faster rise in premium than that due only to increases in medical cost trend. This is approximately 40% of all enrollment in Premera Individual and Small Group plans in Washington.

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In all model scenarios, there is no expected change in the projected premiums or level of provider payments in the counties where Premera is assumed not to have market power. However, the level of increases in premium, or the pressure to slow the growth in provider fees in the counties where Premera has market power would produce changes in the average across the line of business.

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If Premera uses market power to reach target operating margins by both raising premium and slowing provider fee increases, the reduced provider fees will benefit the corporate operating margin as well as the results in the Individual and Small Group lines of business because the reduced fees would be paid to those providers for Premera members in all lines of business.

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10. BLUE CROSS BLUE SHIELD MERGERS, ACQUISITIONS AND CONVERSIONS

This section summarizes the status of recent proposed and completed mergers and conversions of Blue Cross and Blue Shield plans and comments on their potential relevance to the proposed conversion of Premera Blue Cross.

Background

Mergers and conversion of not-for-profit Blue Cross and Blue Shield plans are not unique in the health care market. Similar consolidation and conversion trends have occurred among hospitals and among health plans that began operation as health maintenance organizations (HMOs). But the long standing history of Blue Cross and Blue Shield plans, dating to the late 1930's and 1940's, their distinct state tax and regulatory status, national brand recognition, and often, leading or dominant market share, has focused public attention on Blues transactions.

A starting point for the history of consolidation and mergers among Blue Cross and Blue Shield plans dates back at least to 1982 when the Blue Cross and Blue Shield Association was formed as a result of the merger of the Blue Cross Association (an outgrowth of hospital associations and a spin off of the American Hospital Association) and the National Association of Blue Shield Plans (an outgrowth of physician county medical association plans). An earlier history would document mergers and consolidations among the many county based hospital and medical association plans.

The number of independent Blue Cross and Blue Shield plans has dropped from over 125 in the early 1980's to 63 in 1996 and down to 41 today.[78] Initially, consolidation was primarily among geographically adjacent plans that retained not-for-profit status.[79] Since 1995, over half of the states have seen consolidation activity among Blue Cross and Blue Shield plans and a visible subset of these have been acquisitions and for-profit conversions of Blues plans

[78] This number counts Cobalt Corporation (Wisconsin) as an independent plan. It recently announced plans to merge with Wellpoint Health Networks.

[79] For example, the parent company of Wellpoint Health Networks, Blue Cross of California, is the result of a merger between BC of Northern California and BC of Southern California in 1982. WellCHOICE, formerly Empire BCBS, was the result of the merger of BCBS of Greater New York and BC Northeastern New York in 1985. In Ohio, five BCBS plans have consolidated into one plan.

that had been organized as not-for profit or mutual insurance companies under state insurance laws.[80]

The 41 parent BCBS corporations insure over 84 million members in the United States. The four for-profit publicly traded Blues plans have approximately 25% of this membership.

The growth of the for-profit Blues plans began in the mid 1990's. The earlier transactions were approved by the state insurance regulators and established the precedent of endowing not-for profit foundations to receive the benefits of the conversion and to continue the company charitable purposes. To the extent that state law had not anticipated such conversions, a number of legislatures passed non-profit conversion laws.

The following section presents a brief description of the major mergers and conversions of Blue Cross and Blue Shield plans during the 1990's. The current marketplace has two multi-state for-profit Blues plans, Wellpoint Health Networks and Anthem. There have been at least four single state health plan conversions.[81] Each of these plans, except for Well CHOICE (the conversion of Empire BCBS in early 2003), have since been acquired or merged with either Wellpoint or Anthem. Other plans that have pursued conversion have had acquisition discussions with these or other plans. More recently, a number of proposed transactions have encountered difficulties that have resulted in denial by the insurance commissioner or withdrawal of the plan's application.

Multi-State Non-Profit Blue Cross Blue Shield Plans

There are two major alliances of non-profit Blue Cross and Blue Shield plans that cross state lines. These two organizations proposed an affiliation agreement in March 2001, but withdrew the request in August of that year.[82]

Health Care Service Corp

Health Care Service Corporation, a non-profit mutual insurance company, holds the license for three Blues plans: Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Texas and Blue Cross Blue Shield of New Mexico. It was originally formed in 1975 from the

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[80] Blue Cross and Blue Shield plans have been subject to Federal taxation, with partial exemptions for those organizations engaged in charitable or quasi-charitable activities, since their tax years beginning after December 31, 1986. (Internal Revenue Service Manual section 7.25.41.4 and Internal Revenue Code 833(b).) An IRC 833 corporation is subject to a "no private gain" requirement such that "no part of its net earnings [may] inure to the benefit of a private shareholder or individual."

[81] Trigon (VA), RightCHOICE (MO), Cobalt (WI) and WellCHOICE (NY). Triple-S, the BCBS plan for Puerto Rico, was incorporated as a for-profit.

[82] Press Release. Regence Blue Shield, March 15, 2001 and August 15, 2001.

merger of the separate Blue Cross Hospital Services Corporation and the Chicago based Illinois Medical Service as Health Care Service Corporation (HCSC). It acquired the last stand-alone BCBS plan in the state in 1982. The most recent financial report, for CY 2002, reported $7.2 billion of premium and managed care revenue.

The Regence Group

The Regence Group was formed in 1995. The affiliated plans enroll over three million members in Blues plans in Idaho, Oregon, Utah and Washington and have annual premium revenue of $6.4 billion. Regence Blue Cross Blue Shield of Oregon is a nonprofit statewide plan. Regence Blue Shield in Washington is a nonprofit health service contractor that has the Blue Shield mark for 22 counties and is expanding to the remainder of the state through it's a non-Blue brand. Regence Blue Shield of Idaho is licensed as a mutual insurance company and serves over 260,000 members throughout the state and in Asotin and Garfield counties in southeast Washington. Regence Blue Cross Blue Shield of Utah serves over 600,000 members in that state.

Multi-State For-Profit Blue Cross Blue Shield Plans

Although these plans have been for-profit for less than ten years, each has strongly influenced the changing perception of Blue Cross and Blue Shield plans in the marketplace.

Wellpoint Health Networks

Wellpoint Health Networks was the one of the first for-profit conversions of a BCBS plan. It was created in 1996 with the merger of Wellpoint, the for-profit managed care subsidiary initially formed in 1993 with a partial public offering (IPO), into the parent company, Blue Cross of California. The IPO raised over 3 billion dollars and was used to establish two health care foundations, The California Endowment and The California Health Care Foundation. Wellpoint has since acquired two BCBS plans, in Georgia and Missouri, has unsuccessfully bid on others (Colorado), and was recently denied in its application to acquire CareFirst, the Blues plan that serves Maryland, the District of Columbia and parts of Virginia. In its seventh bid for a BCBS plan in the past five years, Wellpoint recently announced an agreement to acquire Cobalt, the for-profit BCBS plan in Wisconsin.

Wellpoint has separately acquired the medical insurance business of non-Blues insurers, including Massachusetts Mutual, John Hancock, Rush Prudential (Illinois) and most recently, Methodist Care health plan in Texas. These non-Blues programs are marketed nationally under the HealthLink and the Unicare brand. Wellpoint enrolls over 13 million medical

services members and serves over 50 million members through medical, pharmacy, mental health, dental, and other specialty plans.[83]

Anthem, Inc

Anthem, Inc., based in Indiana, has been a major purchaser of Blue Cross and Blue Shield plans. Prior to its conversion from a mutual to a for-profit publicly traded company in October 2001, it had merged or purchased Blues plans in Kentucky, Ohio, Connecticut, New Hampshire, Colorado, Nevada, and Maine. Just prior to its own public offering, the Kansas insurance commissioner denied Anthem approval to purchase Blue Cross and Blue Shield of Kansas. That decision was appealed and the Kansas Supreme Court recently upheld the denial. In the fall of 2002, Anthem completed the purchase of Trigon Healthcare Inc., the Blues plan in Virginia that had converted from a mutual to a publicly traded company in 1997.

Anthem provides medical insurance, primarily under the Blue Cross and Blue Shield service marks, to approximately 11.5 million members.

Single State For-Profit Blue Cross Blue Shield Plans

Many of the Blue Cross Blue Shield conversions over the past decade occurred in states where laws were not specific about the continuation or transfer of assets to fulfill charitable trust obligations. As a result, some conversions were challenged and, for the most part, have resulted in the establishment of health care foundations. A number of these plans have been subsequently acquired and approval of the acquisition has helped to increase the value of the charitable foundations. Currently, there is one single state for-profit Blues plan, WellCHOICE (former Empire Blue Cross), which converted in early 2003.

RightCHOICE Managed Care, Inc

Blue Cross Blue Shield of Missouri, which covered most of the state except the area of Kansas City, restructured its managed care business as a for-profit under the name RightCHOICE Managed Care Inc. in 1994. In late 1998, Blue Cross Blue Shield of Kansas City expressed interest in purchasing the plan, but the offer was not accepted. It operated as a single state for-profit Blue plan until Wellpoint Health Networks announced a purchase agreement in the fall of 2001 at nearly double the share price. The acquisition was completed in 2002.

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[83] Hoover's Company Profiles. Wellpoint Health Networks, Inc.

Cerulean Companies

Blue Cross Blue Shield of Georgia filed for conversion in 1996. It was approved by the Commissioner of Insurance, but did not require the establishment of a foundation or other plan to fulfill charitable trust obligations. In response, consumer organizations filed suit, claiming that the state law was unconstitutional because it did not require the proceeds to benefit charitable purposes. A settlement in July 1998 provided for a transfer of $70 to $80 million to a charitable foundation. On the same day, Cerulean announced that it would be purchased by Wellpoint Health Networks.

The Wellpoint acquisition was delayed by a lawsuit on behalf of BCBS Georgia policy holders who had not replied to an offer of stock at the time of the initial conversion in 1996. Wellpoint increased its offer, which was approved by the Cerulean Board in late 2000. The Georgia Insurance Commission approved the Wellpoint acquisition in March 2001 and the transaction was completed later that year.

Trigon Healthcare, Inc

The Blue Cross Blue Shield plan in Virginia, which served most of the state except the Northern Virginia suburbs around Washington, D.C., first converted to a mutual insurer in the early 1990's. The company received approval to convert to a for profit in the mid 1990's and filed for an initial public offering in February 1997. The company operated profitably as an independent for approximately five years. A merger with Anthem was announced in early 2002 and completed in the fall of that year.

Cobalt

Blue Cross Blue Shield United of Wisconsin announced its intent to convert to a for-profit in June 1999 and offered to donate $250 million of the proceeds to medical schools in the state. The conversion was approved by the Insurance Commissioner in March 2000. The decision indicated that, under state law, there was no charitable trust obligation, but approved a plan to transfer the proceeds to a fund to benefit the medical schools. Consumer groups challenged the finding, asserting that 100% of the assets should be transferred. The commissioner's decision was upheld by a trial judge and again by the Wisconsin Court of Appeals. The conversion plan was finally approved in March 2001. The company became a publicly traded for –profit corporation later that year. In June 2003, Cobalt and Wellpoint announced an agreement to merge. The transaction is expected to be complete before the end of the year.

WellCHOICE

Empire Blue Cross Blue Shield, which serves 4.8 million members in metropolitan New York, including parts of New Jersey, first filed a conversion plan with the New York

Department of Insurance in 1997. Although initial hearings were held, the Greater New York Hospital Association and a union, SEIU, indicated interest in the plan. Empire rejected the offer, but a campaign by the association and union delayed further action until 1999, when the Department of Insurance approved segments of the conversion plan. In March 2000, the Office of the Attorney General approved the valuation and foundation components of the plan.

Empire BCBS revised their plan of conversion in June 2001 by offering half of the estimated value, approximately $500 million to the hospital association and the SEIU. The governor and the state legislature intervened to pass a law that earmarked most of the money to salary increases for hospital workers and left an estimated 5% of the proceeds for a foundation.

Empire BCBS proceeded with its public offering in November 2002, raising $417 million and changing its name to WellCHOICE, Inc. Proceeds of the sale have been frozen by judicial order because of a lawsuit by Consumer Union and other groups that challenges the transfer plan adopted by the legislature. WellCHOICE is currently the only independent for-profit Blue Cross Blue Shield plan.

Incomplete Transactions to For-Profit Blue Cross Blue Shield Plans

Blue Cross and Blue Shield of Kansas

At the end of May 2001, Blue Cross Blue Shield of Kansas announced an alliance agreement with Anthem of Indiana and submitted a proposal to convert the mutual insurer to a for-profit. Separately. Anthem submitted its proposal to convert to a for profit to the Indiana Department of Insurance. After hearings, the Kansas commissioner denied the application for acquisition and conversion on the basis that the reduction in surplus, which would be transferred to the policy holders and Anthem, and the likely increases in premium were not fair and reasonable to policy holders or the public.

Anthem appealed the decision to the County District Court that overturned the commissioner's decision. The Commissioner's office appealed to the Kansas Supreme Court. In a unanimous decision in August 2003, the Supreme Court reversed the District Court decision, holding that the Commissioner had acted within the scope of her authority and that evidence presented at hearings supported the decision. Neither Blue Cross Blue Shield of Kansas or Anthem, now a publicly traded for-profit insurer, are expected to take additional action in the near future.

CareFirst

The history of the CareFirst conversion proceedings dates back to 1994 when Blue Cross Blue Shield of Maryland first proposed conversion to a for-profit corporation. That plan was rejected by the Maryland Commission of Insurance. In 1998, the company completed a merger with Group Hospitalization and Medical Services, Inc. of the District of Columbia, and was incorporated as a non-profit under the CareFirst name. It has subsequently affiliated with Blue Cross Blue Shield of Delaware.

CareFirst filed a new application for conversion with the Maryland Insurance Commission in January 2002. The transaction proposed a conversion to a for-profit corporation and purchase by Wellpoint Health Networks.

The Maryland legislature had passed legislation in 1998 that required health care service plans to transfer all public and charitable assets to a foundation in the event of conversion. The law was amended in 2001 and 2002 and established more rigorous conditions for approval that included evidence that the transaction would be in the public interest, that proceeds or the purchase price be transferred in cash, and restrictions should be placed on executive compensation.[84]

The Maryland Insurance Administration denied the conversion application and purchase by Wellpoint on March 5, 2003. The Commissioner concluded that the transaction was not in the public interest. The major findings were that the corporate decision-making process was flawed, that the purchase price did not reflect fair value, that appropriate steps were not taken to insure that no officer received immediate or future bonuses, and that certain documents were not submitted and therefore there was insufficient information to evaluate whether the transaction would have an adverse impact on the availability or accessibility of health insurance.

Blue Cross Blue Shield of North Carolina

Blue Cross Blue Shield of North Carolina originally filed an application for conversion in January 2002. Supplemental filings and an amended plan of conversion were submitted by July 2002.

State legislation passed in 1998 defines a conversion if 40% of the corporate assets are converted to a for-profit corporation and the full fair market value must be transferred to a health care foundation.

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[84] Community Catalyst. Blue Cross Blue Shield Update. http://www.communitycat.org/index.php3?fldID=104

On July 8, 2003, Blue Cross Blue Shield of North Carolina notified the Commissioner of Insurance and issued a press release withdrawing its application for conversion. The press release cited concerns regarding the dissemination of confidential business information that might be made available to competitors and the extent of regulation and oversight compared to other for-profit insurers.[85]

Horizon Blue Cross and Blue Shield

Horizon Blue Cross Blue Shield, which serves 2.8 million members in the state of New Jersey, had been discussing a possible conversion of the plan to a for-profit for a year and a half, but had never filed an application with the New Jersey Department of Insurance. On August 14, 2003, after Blue Cross Blue Shield of North Carolina announced its plans to withdraw the conversion application in that state, Horizon announced that it would not pursue conversion. The memo to employees specifically referenced the difficulties that other plans had faced it their conversion process and stated that the process might be similar in New Jersey.

Table 11-1 provides a summary of conversion activity for Blue Cross and Blue Shield plans.

Table 10-1
Blue Cross Blue Shield Plans
Consolidations, Acquisitions and Conversions

Plan	Transaction Date	Comments
Multi-State Plans/Non-Profit and Mutual Insurers		
Health Care Service Corp		Mutual Corp 8 million members
BCBS Illinois	BC and BS merger in 1975 dba HCSC	Parent Organization
BCBS Texas		not-for-profit
BCBS New Mexico	July 2001	
The Regence Group	1995	
BCBS Oregon		
BS Washington		
BCBS Utah		
BS Idaho		
For Profit Publicly Traded		

[85] BCBSNC Press Release. BCBSNC Trustees Vote Unanimously to Withdraw Conversion Plan. July 8, 2003.

Table 10-1
Blue Cross Blue Shield Plans
Consolidations, Acquisitions and Conversions

Plan	Transaction Date	Comments
Anthem Inc	October 2001	Demutualization and IPO
BCBS Indiana	1985	Parent organizations established in the 1940's as mutual insurers. Blue Cross of Indiana and Blue Shield of Indians merged in 1985 dba Associated Insurance Companies.
BCBS Kentucky	1993	First cross-state merger of BCBS plans; acquired as part of Southeastern Mutual Insurance
Community Mutual (BCBS Ohio)	1995	Merger Adopted Anthem name
BCBS Mutual of Ohio	1996-1997	Majority sale to Columbia/HCA denied; BCBS service mark revoked and transferred to Anthem
BCBS Connecticut	1997	Merger
BBCBS New Hampshire	1999	Acquisition
BCBS Colorado and Nevada	1999	Acquisition
BCBS Maine	2000	Acquisition
Trigon Healthcare Inc. (BCBS Virginia)	2002 ; Acquisition of for profit plan	Trigon had converted from a health services corporation to a mutual company in 1987. It won approval for conversion to a for-profit corporation in 1996 and became for profit publicly traded company in 1997
Transactions Not Completed		
BCBS New Jersey	1997	Cancelled
BCBS Kansas	Denied 2001 Denial Upheld on Appeal August 2003	
Transactions: Non-Blues		
Federal Kemper	1992	Diversified Insurer

Table 10-1
Blue Cross Blue Shield Plans
Consolidations, Acquisitions and Conversions

Plan	Transaction Date	Comments
Wellpoint Health Networks	IPO 1996	Wellpoint managed care subsidiary of BC California public offering in 1993; Merger with parent and full conversion in 1996
BC California	1982	Parent organization Merger of BC Northern California and BC Southern California in 1982
Cerulean Companies (BCBS Georgia)	2001	
RightCHOICE Managed Care (BCBS Missouri)	2002	The Missouri Foundation for Health
Cobalt Corporation	2003	Announced Acquisition June 2003; Completed September 2003
Transactions Not Completed		
CareFirst (Maryland, DC, VA)	Denied 2003	
Transactions: Non-Blues		
Health Systems International (Now part of Foundation)	Proposed deal cancelled 1995	
Massachusetts Mutual	1996	
John Hancock	1997	
Rush Prudential	2000	
Aetna	Proposed Buyout Rejected 2000	
Methodist Care (Texas)	2002	
RightCHOICE Managed Care	August 1994	
BCBS Missouri		
Cobalt Corp IPO as UNITED WISCONSIN SERVICES, INC.	March 2001	IPO as United Wisconsin Services

Table 10-1
Blue Cross Blue Shield Plans
Consolidations, Acquisitions and Conversions

Plan	Transaction Date	Comments
BCBS Wisconsin		Parent Organization IPO as UNITED WISCONSIN SERVICES, INC. The Wisconsin United for Health Foundation Agreement to Merge with Wellpoint announced June 2003
WellCHOICE	November 2002	IPO
Empire BCBS (New York)		Parent Organization Merger BCBS Greater NY and BCBS Northeastern NY in 1985
Horizon Blue Cross Blue Shield (New Jersey)	August 2003	Announcement it will not seek for profit conversion

11. CONCLUSIONS

Premera's conversion from a not-for-profit to a for-profit organization may have a number of effects. Among our key considerations were external factors that may affect Premera's market position and pricing strategies.

Our review of Premera's operations highlighted several concerns. Among them are a business plan that does not achieve the target operating margins that are likely to be demanded by the financial markets, enrollment growth assumptions that may be aggressive given the current state economy, an expense allocation methodology that is inconsistent with pricing guidelines and may distort expected operating results by product and line of business, and evidence of market power that could be used to raise premiums faster than market trend for members in select geographies and lines of business.

Offsetting these negative considerations are positive outcomes that may derive from the Foundation that would be created under Premera's plan of conversion. Should Premera's stock attain maximum value, a substantive Foundation in the State of Washington would be created. The precise role of the Foundation has not been determined, and consequently the impact of the new funds is not known.

Review of Findings

The following section reviews the report findings and highlights the evidence in support of these conclusions. It also addresses our response to questions and issues raised in the original consultant instructions and others that were added during the course of the engagement.

Accenture Study

- **The Economic Impact Analysis of the proposed conversion of Premera Blue Cross has addressed the major potential issues of a for-profit conversion of a health insurer that are raised in the Accenture study of the proposed conversion of CareFirst, Inc and merger with Wellpoint Health Networks.**

Directions to the consultants included a request to review the "Accenture" study.[86] The report is a community impact analysis of the proposed CareFirst transaction by the Accenture consulting firm. It reviewed the proposed conversion of CareFirst, Inc. of Maryland to a for-profit entity and the proposed concurrent merger of CareFirst, and Wellpoint Health Networks. The report focused on the potential impact of a conversion on the availability, accessibility and affordability of health insurance and health care services. The Accenture report reviews background and financial information on the company, describes the health care resources in the CareFirst service area, and comments on CareFirst operations, products and pricing. Among the primary findings of the report are CareFirst's need for additional capital and the positive benefits of creating a Foundation through the conversion transaction. These issues are addressed in this report and those of other consultants engaged by the OIC.

In its study of the proposed CareFirst Inc. conversion to a for-profit entity, Accenture raised several points regarding the advantages and disadvantages of such a conversion, focusing primarily on the advantages. Accenture notes the need for additional capital to allow for development of new products, increasing market share, and overall company growth. The Economic Impact Analysis of the proposed conversion of Premera Blue Cross has addressed the major potential issues of a for-profit conversion of a health insurer that are raised in the Accenture study of the proposed conversion of CareFirst, Inc and merger with Wellpoint Health Networks, including potential benefits from the conversion in the form of increased access to capital and the role of a heath care foundation. Because the Accenture report was prepared on behalf of CareFirst, it tends to present the most positive aspects of a proposed conversion. We have considered those positive aspects in our analysis, as well as results of a conversion that may negatively affect policy-holders and the public

Washington Demographic and Economic Characteristics

- **Washington has higher average per capita income and higher rates of health insurance coverage than the national average. It also has a higher unemployment rate and population growth has slowed.**

These characteristics imply that the market for health insurance will not significantly expand in the near future. New health plan enrollment growth is more likely to come from winning business from competitors, possible acquisitions, or development of new markets outside the State of Washington.

[86] Accenture, "Community Impact Analysis of the Proposed Conversion of CareFirst, Inc. to a For Profit Business Entity and the Merger Between CareFirst, Inc. and Wellpoint Health Networks Inc.," January 2002.

- **The population of the state is concentrated in the western urban counties while the eastern counties are predominantly rural and more sparsely populated. The distribution of health care resources has a similar pattern.**

  There is greater competition among health plans and among hospitals and providers in the more urban areas. This has implications for choice and pricing of health insurance products. Our economic analysis, combined with review of pricing regulations, suggest that Premera will need to increase premiums above trend, but will have the ability to do so only in limited areas. Specifically, those areas where Premera has the ability to "set" prices may experience increases as high as 8% to 10% greater than what would be expected if premium followed medical trend. These increases will need to be structured to comply with Washington insurance regulations. The Dimensions products provide greater pricing flexibility for individual and small group products than has been available to date.

Washington Health Insurance Market

- **Premera Blue Cross is the largest health insurer in the state. The most significant competitors are Regence Blue Shield of Washington, the second largest health plan, which competes directly in the Western counties of the state, and Group Health Cooperative, the third largest, an HMO that operates in the Seattle metropolitan area and in Spokane, the largest city in the eastern part of the state.**

  The top three health plans cover 75% of the insured enrollees in the state, but the market share of the plans differ by line of business and geography. Premera and Regence Blue Shield are the leading insurers in individual and small group business, and have similar statewide market share. Large group business is more evenly split but also attracts national and regional health plans. In Western Washington, Premera is second to Regence; in Eastern Washington Premera is the dominant insurer as a result of business it acquired in the merger with Medical Services Corporation, a Blue Shield plan, in 1998.

Pricing Structure Adequacy

- **Changes in operations and the health insurance environment in Washington have allowed Premera to return to profitability after years of losses in the mid-1990s. While financial results have improved, the company has not reached market-based target levels of operating margin in the aggregate; Premera has similarly failed to meet operating targets in specific lines of business.**

  The financial review included actual results by line of business for the period 1997 to 2002. The historical results to 2002 indicate a sustained growth in revenue and a return to profitability. It is assumed that as a for-profit corporation, all lines of business will be managed to profitability and achieve target operating/contribution margins.

The Individual line of business, which is a regulated market in Washington, has moved from losses to near breakeven when measured by operating margin. However, while the Alaska book of business meets the target margin of[ ] , this has not been true of either the Oregon or the Washington book of individual business. The Washington Individual account has operated near breakeven for the past two years. PROPRIETARY MATERIAL REDACTED

The regulated small group business has generally achieved target operating margins for the past four years. However, the results vary significantly by geography. Alaska business has achieved target margins and has recently implemented a rate reduction. Oregon has moved from losses to target operating margins. Overall, Washington small group business has under performed, with Western Washington achieving target levels and Eastern Washington experiencing losses.

Results for large group vary by product and types of accounts. The business was analyzed by two major categories: the insured large groups with Preferred Provider Organization (PPO) and traditional insurance products and the large groups with administrative service contracts (ASC). The health maintenance organization (HMO) and Association business are analyzed separately.

The Premera insured large group business has fluctuated between a[ ] loss and[ ] gain in operating margin and vary by geography. Oregon has achieved target levels and Alaska has approached target levels. In Washington, the Western Large Group business has not met targets while Eastern Washington had losses from 1997 to 2000, but has recently achieved target operating margins. PROPRIETARY MATERIAL REDACTED

The Premera Administrative Services Contract business more than tripled in covered lives between 1999 and 2002, with recent significant growth coming from the Microsoft account. Using an estimate of premium equivalent, this business has averaged about a [ ]loss. PROPRIETARY MATERIAL REDACTED

The Premera Government Business includes civil service workers covered under Federal and State employee benefits programs and state operated programs for low income populations, such as Medicaid and the Washington Basic Health Plan. [

PROPRIETARY MATERIAL REDACTED

] Because prices are determined by the government agency, if a company does not achieve break-even, it must initiate cost savings or may decide to exit the market.

[

PROPRIETARY MATERIAL REDACTED

]

programs for low income populations, Healthy Options, the Medicaid managed care program, and the state subsidized program, Washington Basic Health Plan, [redacted] Proprietary Material Redacted

Premera has stated that it evaluates its participation in these programs on an annual basis and will withdraw its participation from the programs if they are not profitable. Recent declines in the performance of the accounts suggest Premera's participation is at-risk.

- **Given that most of the major lines of business in Washington have not attained market-based target operating margins, Premera products appear to be priced below levels appropriate to cover costs and generate required capital.** [redacted]

Proprietary Material
Redacted

Reserve Adequacy

- **The external auditors review reserves at least annually. Reserves are analyzed by major business segment as well as for the company as a whole. PwC has reviewed Premera's reserve adequacy for 1997 through 2002. Although the process and controls are appropriate and the year 1999 was deficient due to data problems caused by a systems conversion, the reserves over time have been adequate, and margins appear to be generally consistent and appropriate.**

The external audit staff has conducted testing of controls. Testing included reconciliation of claims systems and the general ledger, processing backlogs, reserve methodology and prior period reserve estimates. The external auditor found the systems in place to be effective. Our review of the detailed 2002 workpaper support indicated standard actuarial and financial assumptions and processes were used. Premera has used generally accepted actuarial methodologies and procedures to calculate the claim reserves.

Projection Assumptions

- **Premera Blue Cross' financial projection model relies on assumptions regarding health care cost trend, sales and general administrative cost trend, changes in enrollment, and allocation of expenses across lines of business to project operating margins. General assumptions on health care cost trend are reasonable.**

The financial review included historical results and projections for the five-year period 2003 to 2007. The consultants were given a base model and two alternative scenarios. The projection model included detail by line of business and by product and provided information on assumptions regarding medical cost trend, administrative cost trend, including components for premium taxes and sales commissions and general administrative expense, and investment income. Assumptions about enrollment changes indicate expected areas of growth and entry and exit from lines of business. The economic analysis focused on the baseline projection model and examined results for the products and lines of business at the operating or contribution line of the income statement. The reasonableness of the assumptions regarding investment income, depreciation, income taxes, and other non-operating line items are analyzed in other consultant reports.

A review of the reasonableness of the assumptions used in the projection model indicates:

[PROPRIETARY MATERIAL REDACTED]

- Overall medical cost trends appear to be reasonable. [PROPRIETARY MATERIAL REDACTED]

- [PROPRIETARY MATERIAL REDACTED] This is a result of premium growth that tracks assumptions of medical trend and a relatively constant administrative cost ratio. This level of net operating margin is in line with Blue Cross and Blue Shield system wide results, but is lower than most profitable publicly traded health plans.

- Premium taxes and sales commissions increase in proportion to increases in premium and standard sales commissions for each line of business. Current premium tax rates and commission expense are used and are reasonable assumptions for the projection model.

[PROPRIETARY MATERIAL REDACTED]

➢ **Premera may have to gain market share from competitors or new markets to meet Washington enrollment goals. To the extent that enrollment gains cannot be achieved in Washington, growth must be achieved in expansion markets.**

For the Washington based business, the enrollment growth rate assumptions are higher than the expected natural population growth rates for the state. This implies that Premera must attract new members from competitors and/or develop new markets that will attract members who may not have had insurance coverage. To the extent that enrollment growth is not achieved, revenue growth will not meet targets. Although this would mean a decrease in claims cost, the company would also have to reduce administrative costs to meet projections.

Projected enrollment growth in Washington varies by product line and by geographic market. [

PROPRIETARY MATERIAL REDACTED

]

- **Analysis of the projection model identified inconsistencies in the expenses allocated through corporate financial reporting and the pricing and underwriting formulas used to price Premera's products. Resolution of the inconsistencies is a first step in properly analyzing profitability by product, and developing strategic measures related to growth initiatives. Achievement of target-operating margins requires appropriate allocation of expenses.**

Most components of the projection model are specific to a product and line of business, including premium, health care costs, premium taxes and sales commission expense. General administrative expenses are allocated according to corporate guidelines administered through financial reporting. The projection model appears to allocate more expense than competitive market conditions will support. To the extent that this is true across lines of business, accurate expense allocation is a major component of the inability to achieve target operating margins.

The analysis of pricing requires a corollary analysis of operating [or selling, general & administrative (SG&A) expense. The majority of the components used in the pricing of products by Premera are directly allocable to a specific product, and account type. The components directly allocable include premium, incurred claims, commissions and premium taxes. However, operating expenses are allocated through a separate methodology administered in the financial reporting department. The analysis determined certain inconsistencies between the expenses allocated in the course of financial reporting versus the pricing and underwriting formulas and procedures we also reviewed. In general, the large group and large group ASC business is allocated more expenses than the pricing of the products can support. Since the individual (excluding

Medicare Supplemental) and the small group products file expenses consistent with those seen in the financial reports, a major contributing factor to Premera's inability to achieve pricing targets is the additional expenses the products must absorb.

- **The results of the financial projection model of Premera Blue Cross do not meet the market-based expectation that most lines of business should attain target operating margins.**

  Consolidated financial results in the projection model do not reach the target operating margins by line of business. Net income, while increasing, is at the low end of profits achieved by publicly traded health insurers. While these model results may be considered "reasonable" given the historical performance and the uncertainty of market conditions, they also indicate that performance must improve to meet the operating targets.

  The projections indicate that Large Group and Large Group ASC will struggle to achieve target operating margins. The projection seems more appropriate for the prior targets of a not-for-profit company, rather than targets that will be demanded in the investment community. This is especially the case when much of the growth in premium and market share will be concentrated in the Large Group (including ASC) account segment. Also, since the large group segments aren't achieving profit targets, it seems inconsistent to project Individual and Small Group to decrease over the five-year horizon, especially with the risk of the investment in Arizona, a new geographic region to learn the "lay of the land".

Options For Achieving Target Operating Margin

- **Premera Blue Cross can adopt a mixture of strategies to improve target operating margins. It can increase revenue, reduce costs, or a combination of the two. The Premera projection model takes into consideration reductions in administrative and health care costs anticipated as a consequence of the roll-out of Dimensions; the projection model does not provide guidance on how further improvements would be made.**

  Improvements in financial results may be accomplished by increasing revenue, decreasing costs, or a combination of the two. Increased revenue would come from increases in premium or fees above what is assumed in the projection model. Decreases in costs could come from reductions in the cost of health care or reductions in administrative expense. To reduce health care costs below trend, there must be reductions in the utilization of services, the price paid for services, or both. Lower utilization may be accomplished through such activities as disease management and adoption of more stringent managed care practices. Reductions in unit cost result from

lower payments to providers. Other cost reductions may come from lower administrative costs. A strategy that can combine all three is to exit unprofitable types of business.

Strategies to increase revenue will have an impact on members and employers while strategies to lower health care costs will have an impact on providers. Neither may be affected if all improvement comes from reduction in administrative expense.

The projection model provides limited insight into what strategies or combination of strategies Premera might adopt to achieve target operating margin because management projections do not reach the target levels.

- **It will be difficult for Premera to implement strategies to achieve the target operating margins given general economic and health care market conditions.**

Premera has limited ability to increase revenue by raising premiums over health care trends. Competition among health plans in the urban areas and for large group business will restrain premium increases; membership in the geographic areas and lines of business where there may be ability to increase premium over trend are small and will not raise sufficient revenue.

Revenue growth may also come from adding membership, but additional membership will not improve financial results unless the new business has better operating margins than the existing business. It is difficult to add membership if premiums are increasing above the market rate. The implication is that improving operating margin may put more pressure on cost reductions.

There is little indication that management can lower the trend in health care costs. The projection model has health care cost trend closely following premium trend and incorporates expectations about lower provider costs in the Dimensions product. This implies that greater reductions in health care costs are not anticipated.

The projection model already incorporates assumptions of administrative cost reductions due to improved efficiencies as well as improvements in health care costs resulting from implementation of the Dimensions product. However, the fact that the company does not reach the target operating margin means that greater reductions are necessary. This is more challenging because a for-profit company has added administrative costs in financial reporting and investor relations. Premera management has not presented evidence to conclude that administrative cost reduction, by itself, can be sufficient to achieve the target operating margins.

Prospective Rate Increases

- **Premera's revenue growth goals will require increases in premiums and enrollment. Additionally, high performing stock companies consistently meet net operating margin goals in all lines of business. The operating results in Premera's projection model will not be adequate to generate the operating margins consistent with those expectations. To reach net operating margin targets Premera will need to either attain greater savings in health care costs or administrative expense or to increase premiums.**

  The prospective rate increases will not be adequate to meet operating margins and net income ratios expected from publicly traded health insurers. [PROPRIETARY MATERIAL REDACTED] The highest performing for-profit insurers have results above 5% operating margin.[87] In order to achieve the target operating margins, overall performance will have to improve. Washington operating margins must increase 1% to 2% above the projection model to be comparable. Because each line of business must independently achieve operating margin, the Washington Individual products will require the greatest increase above medical trend.

- **Premera may be able to increase operating margins in geographic markets and lines of business where the company has dominant market share. This ability is limited to areas in Eastern Washington and to individual and small group lines of business. The Dimensions product may allow Premera to increase rates faster than health care trend for these members and remain within state rate setting regulations for these products. However, our models indicate that the ability to affect such changes is not likely to be sufficient to attain target operating margins for those lines of business. Rate increases of as much as 8% to 10% above expected trend for some lines of business in some geographic areas will be required to reach Premera's goals.**

  Market competition makes it unlikely that Premera will be able to raise rates above trend across the state to achieve the desired financial profitability. Results of economic modeling indicate that the ability to raise rates above trend may be limited to areas where the company has the market power to improve its margins above current levels.

  The economic model results suggest that any attempt to increase premium above medical trend will more likely affect members in Eastern Washington counties where Premera has dominant market share and, within these counties, those members who are enrolled in Individual and regulated small group (1-50 employees) products. Overall, this is a small number of members.

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87 The Blackstone Group. Premera Blue Cross. Executive Summary of Valuation and Fairness Opinion. October 3, 2003.

Subject to the interpretation of regulatory constraints on rate setting in these markets, higher rates of increase may impact as many as 98,000 members that represent 40% of the individual and regulated small group business projected for Washington in 2007. Rates for Individual members in these counties would have to increase approximately 8% to 10% above projected rates of increase, with Regulated Small Group rates increasing 2% to 4% above trend. Under a scenario with an equal ability to lower provider payment and increase premium, the economic model suggests that Individual premiums in high market share areas would increase approximately 5% above trend and Regulated Small Group would increase 1% to 3% above trend. Provider payment rates would also be 2.5% to 5.0% less than would be expected based on health care trend. This would reduce the overall projected medical loss ratio for each of these products by 2%.

- **If Premera does not retain the preferential Federal tax treatment for Blue Cross and Blue Shield plans, the effective corporate tax rate would increase from 20% to at least 35%.**

This analysis focused on operating margins. To the extent that Premera does not retain the Blue Cross Blue Shield preferential Federal tax treatment and must pay a higher corporate income tax, operating targets must be increased to produce contribution margin to cover those added costs. The projection model assumes a corporate income tax rate of approximately 20%. Loss of the preferential treatment could increase the tax rate to a rate that is likely to be 35% or more. [Proprietary Material Redacted] However, if the tax rate increased to 35%, given Premera's current revenue and operating gain performance, post tax operating gain would decrease to 1.0%.

Cost to Develop New Products

- **Most of the effort and cost to develop the Dimensions product for the Washington market has already been incurred and is a significant factor in the cost projections. The costs in the projection model include the last years of FACET information system sale-lease back.**

After accounting for the remaining costs of the FACET information system sales-lease back, the Dimensions product transition is anticipated to yield lower administrative costs. This is expected because of the reduction in the number of operating systems and the enhanced internet based functions that will reduce costs in the area of membership accounting and provider and customer service.

[Proprietary Material Redacted]

PROPRIETARY MATERIAL REDACTED

- **Premera currently participates in Healthy Options, the state Medicaid managed care program, and the Washington Basic Health Plan, a state subsidized insurance program for other low-income individuals and families. [** PROPRIETARY MATERIAL REDACTED **] As a for-profit company, Premera would have greater incentive to exit these programs if financial performance deteriorates. The company has announced withdrawal from the state government PEBB account effective January 2004.**

  Premera management has stated that the company evaluates is participation in these public programs on an annual basis and will only participate in the programs if target operating margins are reached.

Provider Contracting and Payment Levels

- **Premera has one of the largest PPO provider networks in the state of Washington. The Foundation network for the Dimensions product reduces contracted network size, but maintains contracts with 79% of the current PPO providers and 92% of the hospitals. The Heritage network of Dimensions contracts with a provider network that is comparable to the current PPO network.**

  The Dimensions product is designed to offer a choice of networks and to make members and employers aware of the trade-off between provider access and premium price. The greatest differences in the networks will be in the urban areas. In rural areas, because of

the limited supply of providers and regulatory access requirements, the Foundation Dimensions network is often the same as the Heritage network.

- **There is evidence that Premera has used its market power to achieve lower contracted provider prices in Eastern Washington. Premera's ability to drive provider fee levels in Eastern Washington is not expected to be reduced as a consequence of the conversion. There may be greater pressure to reduce fees (or increase fees at a slower pace) to meet operating margin goals.**

  Small Group and Large Group rate filings for Premera indicate that the geographic area factors for many of the current products are lower in Eastern Washington than in Western Washington. In the Small Group filing, the area factors are even lower for the Dimensions product. than they are for the current product portfolio, indicating that contracting for the new product is expected to support a lower premium.

- [Proprietary Material Redacted]

  For small group products, the Dimensions product appears to have increased the cost differential between Western and Eastern Washington geographic areas.

  For large group products, the relationship between Western and Eastern geographic area factors appears to be similar to that of its current products, but the anticipated dollar premium level is expected to move employer groups to Dimensions products with lower network costs.

Conclusions

Premera has shown operating gains in recent years, and has presented a projection model that anticipates operating margins of approximately [ ]% company-wide.[88] Premera's performance to date and future projections are weaker than those of comparable companies. In addition, Premera is untested as a public company. Taken together, Premera's Initial Public Offering (IPO) price will likely be lower than that of its peers. Improved performance will be necessary to enhance Premera's stock value. Premera's operating costs are above the

[88] Corporate projections for 2007. See Table 7-12.

average for its peer group, and the Dimensions product is expected to reduce those levels. These administrative cost improvements are built into Premera's projection models.

Given the current and projected financial position of Premera, it is not likely that the conversion to a for-profit company will provide both maximum value to the public through establishment of a foundation and protection of the members and providers that do business with the company.

If Premera implements strategies to achieve target margins, it will help to assure maximum value of the stock price and increase the assets of the proposed foundation but may have negative consequences for members and providers. If the company maintains the current plan, members and providers may be protected, but the stock valuation would be depressed relative to other for profit health plans and a foundation would not receive the maximum value.

Premera dominates the insurance market in Eastern Washington, with some limited exceptions. Its Dimension product design may allow it to take greater opportunity of its market power in that area, particularly in the individual and small group markets. Premera is one of several carriers operating in Western Washington and is restricted in its ability to increase premiums in those areas.

Premera's market dominance affects its relations with providers, with Eastern Washington providers receiving generally lower payment amounts and reporting a greater level of unhappiness with Premera than those in Western Washington. Geographic area rating factors suggest provider network payments are [ ] to [ ] lower in Eastern Washington for the current Premera products and that the difference may increase to [ ] to [ ] under the Dimensions products. Providers in that geographic area have limited choice regarding participating in Premera networks. These circumstances will be unchanged following a conversion, while pressure to meet financial performance goals will be heightened, putting added pressure on provider relations.

PROPRIETARY MATERIAL REDACTED

Premera has traditionally participated in public programs (Healthy Options and the Basic Health Plan) and purports to assess its participation on an annual basis. [

PROPRIETARY MATERIAL REDACTED

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To the extent that Premera requires additional capital, it may provide Premera the opportunity to expand into new areas. Given current market share, Premera's growth opportunities are limited to winning business from competitors or growth of new markets. Consequently, the capital may be used in large part to allow Premera to grow outside of the State of Washington.

Premera's expense allocation formulas appear to result in subsidization of some business lines. As a public company Premera would be expected to reach target operating margins over time in each business line independently. [Proprietary Material Redacted] It is unlikely that Premera can achieve its growth and pricing goals simultaneously.